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### Dr. Flint Defines Paranoia.

"Now I ask you," Mr. Jerome began, speaking very slowly, "as a result of your scientific study of insanity—what is the fact that you find in regard to the memory of insane persons?"

"In many forms of insanity the memory is not impaired, and in many it is abnormally retentive," Dr. Flint replied.

Thaw was looking at Dr. Flint, and the expression in his big eyes was one of intense interest. He had heard such questions before, and knew what was soon to come. Mr. Jerome continued:

Q.—What is paranoia? A.—Paranoia generally occurs in young adult life. It is progressive and is characterized by delusions or illusions without impairment of intellect, memory, or other powers.

Q.—Is its progress slow or rapid? A.—The progress is always slow, sometimes remaining stationary for years, and the mental deterioration sets in late in life.

Q.—Is it true that paranoiacs are found whose powers of conversation and memory are brilliant? A.—That is true.

Q.—What do alienists mean by insight? A.—Appreciation of one's own mental condition.

Q.—Are the delusions from which a paranoiac suffers always devoid of any foundation in fact? A.—Not always, and they are sometimes based on facts. The delusion consists of an exaggeration or misapprehension.

Q.—What can you say as to the capacity of the insane to conceal their condition? A.—They often do so with considerable success, and this is especially true of paranoiacs.

Q.—What can you say of the presence of the exaggerated ego or grandiosement in paranoiacs? A.—Always present, especially in later years.

### Thaw Insane, Says Alienist.

Dr. Flint then said that there were no physical signs of paranoia observable, and then came the question as to the present mental condition of Thaw.

"In your opinion, is Thaw sane or insane?" Mr. Jerome asked.

"Insane," Dr. Flint replied, with great deliberation.

"Are you able, after your eighty days' observation of Thaw and your study of the documents that figure in this case, to give an opinion as to the form of the insanity from which he suffers?" Mr. Jerome continued.

"True paranoia," the alienist answered.

"Do true paranoiacs ever recover?" Mr. Jerome asked.

"Never," was the cool and deliberate answer.

"Are true paranoiacs suffering from delusions dangerous when at large?"

"They are dangerous at all times."

"To others or to themselves?"

"Generally dangerous to others."

Mr. Jerome then read the hypothetical question based on the history of the Thaw case to Dr. Flint, and asked him if he was able to form an opinion as to the present mental condition of Thaw.

"I am," Dr. Flint replied.

"What is that condition?" Mr. Jerome asked.

"He is insane," Dr. Flint answered.

"In your opinion, could Harry K. Thaw be released from custody without danger to the public safety and peace?"

"He could not."

"That is all; he's your witness," said Mr. Jerome, turning to Mr. Shearn.



**NURSING THE INSANE**



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# NURSING THE INSANE

BY

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HOMEOPATHIC HOSPITAL, MIDDLETOWN, N.Y.

New York

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To

THE NURSES

OF THE MIDDLETOWN STATE HOMEOPATHIC HOSPITAL

IN GRATEFUL RECOGNITION OF THEIR FIDELITY

IN THE CARE OF MENTAL INVALIDS





## PREFACE

WITHIN the memory of the passing generation our institutions for the insane have undergone remarkable changes in aims and character. From being merely places of detention and custody, they have evolved into modern hospitals which aim to provide comfortable, pleasant, and hygienic surroundings for the patients, scientific treatment directed to the cure of the curable, and judicious and humane care for all.

A large number of the population of every State hospital is composed of chronic and presumably incurable cases, but many are susceptible of marked mental improvement, and some of recovery.

These patients make up a large community of peculiar and trying persons. To deal with them wisely and kindly requires exceptional qualities of mind and character. The training of nurses and attendants for these patients must cover a much wider field than is comprised in the course of the ordinary trained nurse. The nurse for the insane must be prepared to care for the ordinary medical and surgical diseases of her patients, in addition to their mental ailments; for insanity does not exempt them from the other ills that flesh is heir to. She must safeguard them from injuring themselves or others, must possess many of the qualities that make a good teacher, since a part of her duty is to help correct faults in early training and development, and to encourage and train to correct and useful habits and proper behavior; she has also to employ and entertain her patients, under the direction of the medical officers; and to her is intrusted that almost constant association and companionship which, if sympathetic and judicious, is one of the most potent means of restoring her charges to mental health.

To this end training schools are now established in all the State hospitals, where students receive special experience and instruction in the care of mental invalids, in addition to the

training ordinarily afforded in general hospitals. This instruction is furnished by text-books, lectures, demonstrations in the operating room, and special clinics at the bedside and on the wards.

This book, which started as a collection of familiar talks to nurses in charge of mental invalids, is the outgrowth of fifteen years' experience in a large hospital for the insane. It does not pretend to cover the entire field of nursing, although many points in general nursing are necessarily included in it. Its aim is to furnish special instruction and suggestions to students engaged in caring for the insane, to help new workers to a right beginning, and to aid the more experienced ones to greater efficiency.

Since my work has been almost entirely among women patients and students, it has seemed natural to address myself to women nurses, although many of the talks themselves were originally given to both sexes, and, in the main, are as applicable to men as to women nurses.

I am aware that there is some repetition of ideas in the book. Written at different times and for different occasions—for probationers, junior, senior, and graduate nurses—it is perhaps inevitable that the work as a whole shows emphasis and reiteration along certain lines. But the things emphasized, the topics that reappear in the various talks, are things, I believe, of vital importance; and the principles I have tried to set forth seem to me so much in need of emphasis that I trust the various ways of presenting them will prove sufficiently helpful to excuse whatever repetition may be noted.

The medical works and books on nursing which I have consulted in the preparation of this volume are too numerous to admit of special acknowledgment; nevertheless, their help is gratefully appreciated. I am also much indebted to several of my confrères for valuable aid in the critical reading of the manuscript.

If this book fulfills its aim, I shall feel it a privilege to have been in any way helpful to that noble body of men and women engaged in the humane service of ministry to minds diseased.

CLARA BARRUS

# CONTENTS

CHAPTER	PAGE
I OUTLINE OF NURSES' WORK IN THE NEW YORK STATE HOSPITALS . . . . .	1
II INTRODUCTORY TALK TO NURSES OF THE INSANE . . .	6
III RULES TO OBSERVE WHEN ON DUTY . . . . .	17
IV THE RECEPTION OF PATIENTS . . . . .	34
V WARD MANAGEMENT AND DUTIES OF CHARGE NURSE .	49
VI HYGIENE OF THE WARDS AND OF HOSPITAL DEPARTMENTS	60
VII THE CARE OF BED PATIENTS . . . . .	73
VIII BATHING AND HYDROTHERAPY . . . . .	89
IX THE PREPARATION AND SERVING OF FOOD . . . . .	113
X PRACTICAL POINTS IN NURSING THE INSANE . . . . .	120
XI THE OBSERVATION OF SYMPTOMS . . . . .	130
XII ACCIDENTS AND EMERGENCIES . . . . .	142
XIII CARE OF SPECIAL MEDICAL CASES . . . . .	168
XIV SOME POINTS IN SURGICAL NURSING OF THE INSANE .	183
XV CARE OF GYNECOLOGICAL AND OBSTETRICAL CASES: PUER- PERAL INSANITY . . . . .	198
XVI OCCUPATION AND AMUSEMENT OF PATIENTS . . . . .	209
XVII SLEEP AND THE CONDITIONS WHICH FAVOR IT: DUTIES OF THE NIGHT NURSE . . . . .	223
XVIII A TALK ON PSYCHOLOGY . . . . .	236
XIX THE POWER OF HABIT . . . . .	252
XX AIDS TO PSYCHIC TREATMENT . . . . .	256
XXI APPLIED PSYCHOLOGY . . . . .	263
XXII MENTAL HYGIENE . . . . .	273
XXIII NORMAL AND ABNORMAL MENTALITY . . . . .	282
XXIV MANIFESTATIONS AND ACCOMPANIMENTS OF INSANITY .	293
XXV FORMS OF MENTAL DISEASE . . . . .	309



CHAPTER	PAGE
XXVI FORMS OF MENTAL DISEASE ( <i>Continued</i> ) . . . .	328
XXVII NURSING IN THE VARIOUS FORMS OF MENTAL DISEASE .	349
XXVIII NURSING THE INSANE IN PRIVATE HOUSEHOLDS AND SANITARIA . . . . .	380
XXIX MISCELLANY:	
Commitment and Conveyance of Patients to State Hos- pitals . . . . .	390
Report of Journey . . . . .	393
Approach of Death, Religious Offices, Signs of Death, Care of the Dead . . . . .	397
Preparation for Autopsies . . . . .	399
Clothing and Belongings of Patients after Death .	400
INDEX . . . . .	401

# NURSING THE INSANE





# NURSING THE INSANE

## CHAPTER I

### OUTLINE OF NURSES' WORK IN THE NEW YORK STATE HOSPITALS

THERE are thirteen State hospitals for the care of the insane in New York State, besides two for criminal insane, and twenty-three licensed sanitarium. In these institutions are treated more than twenty-eight thousand mental invalids. This number does not include the voluntary patients in unlicensed sanitarium, nor the patients being cared for in private households.

With, then, this large number of mentally afflicted to be treated in New York State alone, it would seem desirable that thorough courses of instruction and training should be afforded the young men and women undertaking this humane but arduous work. Such instruction the State hospital training schools aim to furnish.

The State hospitals are under the control of the State Commission in Lunacy (a body composed of three commissioners, aided by a secretary, a medical inspector, an auditor, and a treasurer), whose official headquarters are in Albany, New York.

Applicants who wish to enter the State hospital service may address communications to the Commission, or to the superintendents of any of the hospitals named below:—

NEW YORK STATE HOSPITALS	ADDRESS
Utica State Hospital,	Utica, N.Y.
Willard State Hospital,	Willard, N.Y.
Hudson River State Hospital,	Poughkeepsie, N.Y.
Middletown State Homeopathic Hospital,	Middletown, N.Y.
Buffalo State Hospital,	Buffalo, N.Y.
Binghamton State Hospital,	Binghamton, N.Y.

NEW YORK STATE HOSPITALS	ADDRESS
St. Lawrence State Hospital,	Ogdensburg, N.Y.
Rochester State Hospital,	Rochester, N.Y.
Kings Park State Hospital,	Kings Park, L.I.
Long Island State Hospital,	Brooklyn, N.Y.
Manhattan State Hospital,	Ward's Island, N.Y.
Central Islip State Hospital,	Central Islip, N.Y.
Gowanda State Homeopathic Hospital,	Gowanda, N.Y.

The requirements for entering the service of these hospitals are as follows: men and women of suitable age, preferably from twenty-one to thirty-five, of good character and in sound health, who have passed a non-competitive Civil Service examination at the hospital they wish to enter.

Application blanks may be procured at any of the State hospitals, and at least two satisfactory letters of recommendation must be submitted by the applicant, who needs, of course, to possess a common school education in order to pass the preliminary examination.

On entering the service, the probationer, who is called an attendant, may wear ordinary clothing for one month, after which time, if his or her services prove satisfactory, the appointment is usually confirmed, and the prescribed uniform must then be procured and worn at all times when on duty.

Board, lodging, and laundry are furnished in addition to the wages, which will be mentioned later. In some cases, by special permission of the superintendent, and approval of the Commission, employees are allowed to board and lodge away from the hospital, and then a uniform rate of \$12 a month is added to the monthly wages. Such employees are not entitled to the use of the laundry.

Employees who are off duty as a result of illness not received in the line of duty are not entitled to compensation for time lost.

Attendants and nurses may be dismissed for disregarding rules or for unsatisfactory services. They are expected to present written resignations one month in advance, if intending to leave the service.

The Training School for Nurses aims to offer instruction in

the general care of the sick and special instruction in the care of mental and nervous patients. Attendants showing fitness for the work are earnestly urged to enter the Training School, which holds its entrance examinations in June and early in September in all the State hospitals. A two-year course of lectures and recitations in anatomy and physiology and in general and special nursing, supplemented by practical ward and infirmary work, and hygienic housekeeping, comprises the training. Lectures and recitations last from October 1 till May 1, while the practical work continues throughout the year. Oral and written reviews are held from time to time during the year, and a written examination is held at the year's close. At the end of the two-year course the successful candidates are graduated and appointed as nurses, receiving a State diploma, and an increase of pay if they remain in the service. Postgraduate instruction is also provided in many of the hospitals, in which graduate nurses are helped to more advanced studies than are arranged for in the regular course, and where matters concerning which they have grown rusty or indifferent are brought to their notice.

Applications are frequently made to the State hospitals for nurses trained in the care of the insane, and these hospitals occasionally supply the demand from their list of graduates who are engaged in private nursing.

Nurses and attendants are entitled to an annual vacation of fourteen days; to each fourteenth day after the morning's work is performed, or its equivalent; and to each third Sunday; with full pay during such absences. Night nurses and attendants are not entitled to the fourteenth day. Other absences are granted at the discretion of the superintendent.

Nurses and attendants are graded as follows:—

Monthly Wages:—

Charge nurses: men receive \$35.00 to \$41.25; women, \$28.75 to \$35.00.

Nurses: men, \$31.25 to \$37.50; women, \$25.00 to \$31.25.

Charge attendants: men, \$31.25 to \$37.50; women, \$25.00 to \$31.25.

Attendants: men, \$22.00 to \$30.00; women, \$16.00 to \$22.50.

Dining room attendants: women, \$17.50 to \$22.50.

Special attendants: men, \$37.50 to \$43.75; women, \$31.25 to \$37.50.

Increase of wages from minimum to maximum are at the rate of \$1.00 a month for each six months of continuous service.

Transfer of employees from one State hospital to another may be arranged only by obtaining the written consent of the superintendents of the two hospitals, and in such cases only may the service be regarded as continuous. Discharged employees from one State hospital cannot obtain employment in another without the written approval of the superintendent who discharges them.

Our large institutions for the insane are managed by a uniform system, and while there are individual differences in the various institutions, the rules and requirements, the aims and the advantages, are practically the same in all. The Commission in Lunacy is over the entire hospital service; the superintendents have charge of their respective institutions; they are aided by assistant physicians, stewards, matrons, supervisors, nurses, attendants, and other employees.

The patients, both public and private, acute and chronic, are cared for in the various buildings arranged for their care, in some cases in large structures accommodating a great many, in others in detached cottages, accommodating only a few. Most of the State institutions combine these two methods of housing their patients.

The large buildings contain the administrative quarters, often various industrial departments, the culinary departments, etc. The buildings set apart for the use of patients are usually divided into wards or halls, leading off from which are rooms arranged for one, two, or more patients. On each of these wards, or halls, as a rule, in addition to the rooms above-mentioned, are sitting rooms, dining and serving rooms, dormitories, bath and toilet rooms, linen rooms, and a hospital or infirmary department, where the physically sick, the feeble, and those needing bed treatment are cared for, these cases being under the continual supervision of nurses both day and night.

The nurse in charge of a hall, together with a sufficient number of assistant nurses or attendants, usually rooms on her particular ward; the other nurses and attendants occupy rooms provided for them at the Nurses' Home, detached from the buildings occupied by patients. Meals for nurses are, as a rule, served in the dining rooms provided for patients, but at different times than when the patients are congregated there.

The proportion of nurses and attendants to patients is about one to nine. In the hospital most familiar to the writer, where the number of patients at present is 1340, the number of men nurses and attendants is 77, of women, 81. The force is considerably reduced at night, when a much smaller number is sufficient to look after the same number of patients.

For the most part, women nurses and attendants are employed on wards for women patients, and men on wards for men patients, but it has been found advantageous in many of the hospitals to employ, in addition to the men nurses and attendants, some women attendants for the men's wards also. In many instances, the women so employed are married, and work in company with their husbands on the same ward.

The duties of nurses and attendants may briefly be stated as follows: To familiarize themselves with, and faithfully obey, the rules of the hospital in whose service they engage; to promote the welfare of their patients in respect to bodily, mental, and moral needs; to strive to be loyal to superiors, and considerate and helpful to associates; to refrain from mentioning patients' names, histories, or peculiarities to people outside the service, and from gossiping concerning patients, employees, or officers with any one, inside the service or out.



## CHAPTER II

### INTRODUCTORY TALK TO NURSES OF THE INSANE

I WOULD have no young man or woman lightly engage in nursing the insane. It is work that claims the best of one's powers.

The ideal nurse is one whose bodily presence breathes health and cleanliness, one of quiet garb, of noiseless step, of soothing hand, of cheerful spirit, and of hopeful heart, and one of ready but judicious sympathy. We must not forget the "low and gentle voice" which, if it be "an excellent thing in woman," is especially so in a nurse.

To these qualities must be added punctuality, truthfulness, patience, obedience, caution, courage; a spirit of untiring helpfulness, a vigilance that never sleeps, a sympathy that is inexhaustible, and a tact that can cope successfully with the most trying and complex of situations.

The nurse for mental and nervous invalids needs to be especially careful to conceal prejudices, to beware of showing favoritism, to conquer resentment and antipathies, to study the art of peacemaking, to learn when to speak and when to refrain from speaking, when to act and when not to act. She must learn humility and forbearance; in short, she must so cultivate the virtues that she becomes but little lower than the angels. And here I am reminded of what George Eliot says:—

"To be anxious about a soul that is always snapping at you must be left to the saints of the earth," and you are no saints, but just mortal men and women who have undertaken a work that makes continual demands upon your moral as well as your physical strength. I would not have you think I underestimate these demands. I would only try to help you cope with them as I believe you wish to do, worthily and well.

I wish in this talk to engage the attention not only of beginners in the work, but also that of all nurses and attendants for the insane, to the end that each asks herself whether she is doing her utmost to bring about recovery in recoverable patients, and to ameliorate as far as possible the condition of those who must spend the remainder of their lives in some institution for the insane.

I wish at the outset for each of you to think for a minute what this means — to be always under lock and key, deprived of liberty, subjected to the necessary rules of a large institution, to the authority of the superintendent, and the other attending physicians, to the directions of the supervisor, and sometimes also to the tyranny of attendants, who too often exercise an unwarrantable dictation over patients whom they are expected to care for, to guide, to console, and to encourage, but never to dictate to nor command.

The progressive nurse is always on the alert to learn how she can grow more and more efficient, and here I wish to caution the experienced nurse against thinking there is nothing else for her to learn, no newer and better methods to adopt, no truer application of the old methods.

Those of us who have been in the work many years have to acknowledge that some patients get well in spite of, rather than because of, our efforts; and that others drift into chronicity because we are wanting in the energy and resourcefulness to rouse them to activity and to mental restoration. Have we not seen patients that have been regarded as hopeless, unaccountably take a favorable turn and surprise every one by getting well? Surely such may be said to recover in spite of us; some subtle influences have been at work of which we are not aware. These experiences make us see the necessity of studying into and revising methods needing revision, and of discovering new methods waiting for discovery, perhaps so near at hand that we are looking right over them, though earnestly desiring to see them.

We need to keep step with the advance being made in the study and treatment of nervous and mental disorders. Antiquated ideas and methods must be cast aside for newer, more



enlightened views and methods; routine must give place to individualization. The necessary red tape of an institution must be supplemented by variety and freshness. We must get out of ruts, look at our patients with a fresh eye, and bestir ourselves to try something different if old ways have proved ineffectual.

In our large institutions, it is true, the majority is made up of chronic and supposedly incurable patients, and "to expect a cure when a cure is logically impossible, is illogical." This is a truth we have a right to console ourselves with when we see, in spite of the utmost care, that a patient has drifted into the condition of chronicity. But be sure that the patient has received your utmost care, your best efforts, your unfailing efforts, to stimulate and to restore. Even then, be careful how you regard a given case as incurable. Better err on the side of hoping against hope than to relax in any particular efforts toward bringing about a recovery. Keep alive your own optimism even in the face of discouragement. Optimism is infectious.

One sometimes hears a nurse say: "It is so discouraging caring for these chronic cases. If we could only have something worth working for!" Let me again and again warn you against regarding a patient as incurable; but, even granted that a given case is hopeless, or, suppose your entire service is composed of seemingly hopeless cases, what then? In the first place, it is your duty to minister to a chronic patient's physical wants just as conscientiously as though she were the most promising of patients. The bodily functions should be regularly and closely watched, and any irregularities promptly reported to the physician. Do not take it upon yourself to decide as to their importance; let the physician do that. Your duty is to observe and report. The patient's appetite, the sleep, the functions of urination and of defecation, the menstrual function, the condition of the skin, the habits, tendencies, false beliefs, conduct — all these, and many others not enumerated, should be intelligently and regularly scrutinized by you, and any departure from the normal promptly announced to the attending physician.

Because a patient's reason is dethroned, is the need all the more urgent that her body receive the strictest care of the nurse, so that it may be rendered as wholesome, tidy, and unobjectionable in every sense and to every sense, as possible; not by spasmodic, spiritless efforts, but by continuous, tireless, persistent efforts.

"She has been that way for years," "She *never* brushes her teeth," "She *will* put butter in her hair," "We can't keep her from destroying her clothes" — familiar sentences, are they not? Do you ever think how often you confront the physicians with such replies when they urge you to try to bring about a more desirable state of affairs?

Instead of offering such stock answers, how would it do if you said to yourself, "Because she has been that way for years," or "Because she has this troublesome propensity," or "Because she is so negligent, disgusting, or unruly," "I will set my wits to work to counteract these tendencies, to break up these habits. I will begin work on some different line than has been adopted. I will get her into some new ruts at least. I will no longer stand by and say, 'Because she is that way, she shall continue to be that way.'" Beware of the attitude that shows strict adherence to the Biblical injunction, "Let him that is filthy be filthy still," but rather by a word in season and out of season, by line upon line, here a little and there a good deal, by precept and example, seek to instill into your patients a desire for correct behavior, for doing things "decently and in order," for "ways of pleasantness" and "paths of peace."

Try new and radical means for breaking up old habits. What transformations may result! If every one of you were to work at these reforms with real energy and enthusiasm, your own ingenuity, tact, "mother wit," industry, patience, and perseverance would accomplish wonders! But it must be undertaken earnestly and honestly.

"Susie, button your dress," "Katie, tie your shoe," "Mrs. B., don't follow the doctor down the hall," and the like, uttered in a forceless, half-hearted way — such a method is just so much water on a duck's back; it is even worse than useless, for by uselessly calling attention to it, it only serves to strengthen the brain impression of the particular fault, and it only lets you

delude yourself that you are disciplining the patient and mending matters, whereas you have left the condition unimproved, plus the fact that you have actually aided the patient to persist in undesirable conduct; yet you really wish to aid her to desist.

How would it do, for example, if, other efforts having proved unavailing to prevent, say, a patient from putting butter in her hair, you applied to the physician for a small box of vaseline for the patient's personal use? The chances are that this attention would please her, notwithstanding her deterioration, and that she would take kindly to the substitution — some oil being the main thing desired in this connection. The comfort to your own olfactory sense by this substitution ought to be enough reward, even were there no other consideration.

It is surprising, too, for example, how in the matter of using a toothbrush, a painstaking nurse can inculcate habits of tidiness even in the hopelessly demented. She can sometimes appeal to a patient's vanity, sometimes mention what a difference clean teeth make in the taste of one's food, or in the influence on the breath, or, if none of these avail, she can as a matter of routine see that such patients attend daily to this part of their toilet just as she should that they attend to their other needs, to the bowels, the food, medicine, and exercise; for there is a large class of patients in which all these wants have to be superintended by the nurse, and to say that a patient never brushes her teeth, for example, is no excuse whatever. If she does not, the nurse is there to see that it is done, or to do it for her when she proves intractable.

There is no need to multiply examples. Each case calls for a fresh application of energy, ingenuity, and perseverance on your part, and in just the degree that you show yourself active, resourceful, and indefatigable in meeting these trying questions, in just that degree will your value be felt as an efficient nurse.

I always feel that a nurse is honestly willing to better conditions if she meets suggestions with a cheerful, "I'll try, Doctor," instead of that everlasting answer, "It is no use trying — you can't do anything with *her*." By the nurse's willingness to coöperate, she puts herself in the right mental attitude to gain the victory over the point in question; she has taken the first

step necessary — the step of conquering her own indifference in the matter. She is therefore in a position to put her wits to work, to summon her resources, and to bring about desired results. It is the old story of "I'll Try" conquering where "I Can't" invariably fails. It is incalculable, too, how much more interesting and inspiring you will find the work if this attitude is taken and persisted in, than it is to jog along in a routine way.

I have seen a new and energetic nurse take charge of a room full of chronic patients who had been allowed by a former nurse to eat with their fingers, shoving in the food in a most repulsive way; in a few weeks' time I have seen that nurse's painstaking efforts rewarded by an orderly set of patients decorously feeding themselves with spoons from neatly arranged trays, the same cases that other nurses had declared could not be made to do differently. But this transformation was not effected without patience, perseverance, tact, and a careful study of, and attention to, each individual patient; for what works well with one will often have no effect upon another.

There is always this point to be kept in mind, too, that by your efforts you can prevent less hopeless cases from sinking into the dilapidated ways which more extreme ones have adopted. The latter patients should furnish a constant warning to us to leave nothing untried to prevent such a result.

There are other duties to be performed for the chronic patient besides looking after the bodily health and appearance. Her comfort and enjoyment are none the less important because fate has deprived her of some, even many, of her faculties. The more she has been deprived, the more is it your bounden duty to help compensate her for this loss. Her tranquillity, happiness, desires, even her harmless whims, should be ministered to as far as in you lies, always keeping in mind the patient's good in judging how far you can indulge her, and, in addition, the greatest good to the greatest number, not, of course, catering to the whims of one person to the annoyance of many others.

Because a patient is deluded and unreasonable, you are not excused from taking precautions, or from resorting to expedients which might serve to maintain or to bring about serenity of

mind and peaceableness of behavior, even though you cannot hope to dispel the delusions giving rise to troublesome conduct.

Suppose a patient likes to cut out and save favorite poems or pictures, or other clippings from the magazines. If she can be trusted with scissors (blunt-pointed, of course), there is no reason why she should not be allowed to do this. The things she saves may be worthless in your eyes, intrinsically worthless, perhaps, but think what they mean to her. Think what that little bag which contains her sole stock of treasures means in her life, you who have your liberty, your friends, your rooms with bookshelves, dressers, wardrobes, and places wherein to keep belongings! Think, and be careful how you ruthlessly destroy or ridicule her poor little possessions! I know of no more pathetic sight in an insane hospital than these pitiful little woolen or cotton bags that many of our patients concoct out of scraps of cloth obtained by hook or crook, in which they store their small belongings, not even in some instances having any place to keep them except hanging on their arms by day or tied on the bed or tucked under the pillow at night. It is the longing for a home, for a place of one's very own, that still survives in the beclouded soul—a remnant of individuality which we should all respect as far as possible. In every way that lies in our power we should seek to individualize each patient; keep him alive to his own personality; do not class him as one of a mass; he has his individual life to live, his own hopes, fears, and desires; his own place in creation; and it is our duty at all times to respect this, to help him to appreciate it, if, by reason of his disordered intellect, he is in danger of forgetting it. Always call patients by name, do not speak of them as “he,” or “she”; let each feel that he is somebody, a particular somebody—not a mere something, grouped in a mass and called “the patients.” I was touched some time ago when a patient who had been with us for several years returned from a visit home, bringing with her one of these little bags above mentioned. Seeing her cling to it as fondly as ever after her sojourn in the world, I made some comment which led her to show me the interior of the shabby receptacle. I have forgotten what made up the bulk of the things; I recall,



among the odds and ends, some letters written by her little girl telling of her standing in school; but what impressed me most was a withered rose that had been given her years before by one of the hospital physicians — carelessly given on his morning visit. The discovery of how that chance act — the bestowal of the rose — had given to the afflicted one a veritable treasure, showed me how little it sometimes takes to make patients happy, and how our casual acts and words often carry comfort, or alas! cause distress that we but dimly recognize either at the time or afterward. One must, however, consider something besides sentiment in this matter. The question has its practical side. Some of you, I know, will immediately think of patients with a propensity for collecting things, and will wonder if I mean that they are to be humored to the full extent of these proclivities. Of course not. This is where common sense and tact must be exercised, though even with such cases I should say, rather err on the side of indulgence than of arbitrary prohibition. A certain nurse gets around this matter tactfully by permitting collections to be made till they reach a considerable size, when the package is tied, labeled by the patient, and sent to the office of the superintendent, and the patient goes on contentedly accumulating others which in time meet the same fate. She knows that when the package reaches a certain bulk it must be carried away; she is happy in the belief that her treasures are safe, and is so intent upon acquiring others that she does not inquire for the old packages after they have passed out of her keeping. No harm is done in catering to this whim, and the capacious wastebasket relieves us of the worthless hoard.

Sometimes the things saved by patients have a real value for them which is difficult for us to estimate unless we can put ourselves in their places. I recall a certain patient who years ago had some literary ability, various manuscripts of hers having been accepted and published in some of the newspapers and magazines. Later a mental disorder put a stop to her productions; she was sent here and there to various institutions in the East and West, and finally drifted to our hospital. In all these vicissitudes she had managed to preserve the printed

articles that to her represented whatever of achievement her life of struggle and aspiration had to show. Think what these clippings meant to one now hopelessly stranded in a hospital for the insane, with only the past for comfort! Yet a strenuous nurse one day, intent on clearing out things, dumped them with "other rubbish," as she said, into the waste; before the fact could be reported and a search instituted, they were gone past recall. The patient's grief at the loss was a painful thing to contemplate. The nurse was very sorry when she learned the full import of what she had done, but that could not bring back the treasured relics to the patient.

Bear in mind that each person has her individual habits and whims, some of them absurd, some troublesome in the extreme, some harmless. When they are harmless, humor them. You will, by yielding in non-essentials, often win a victory in essentials, for patients are susceptible to kindness that comes from the heart, and honest endeavors to please them and to add to their daily comfort will meet answering if feeble echoes in the hearts of those whose minds are hopelessly beclouded.

Think what you are doing in adding even a modicum of pleasure to the lives of your unfortunate charges! What little pleasures, what childish enjoyments yet remain for them in their cheerless lives — and these are so largely dependent upon the offices and the spirit of the nurse under whose care they are placed! The friends of our patients can do much to relieve their unhappiness, the physicians can do perhaps still more — alas! more than we do do, each of us, if honest, must admit — but the nurse, whose association with the patient is so direct, so constant, and so intimate, has it in her power to do more than all others in this line.

It needs but a little concentration of our thoughts upon this subject to convince each of us that he is in duty bound to contribute his share of sunshine to these beclouded lives, debarred as they are from the many pleasures that come to persons with sound minds.

There is a trite saying to the effect that we must take things as we find them. True, but we are under no restrictions to leave them as we find them, and this is the thought I wish to



impress upon you at the close of our first talk together. Let us be discontented to this extent — that each of us turns his attention upon his own field of work, sees things as they are, and henceforth earnestly resolves and undertakes straightway to make them better than they are.

Waste no time or energy in thinking, "If I only had ward —, or ward —, I would show that I could do something." Right here, in your own field, are the battles you are called upon to fight with disease and delusion. The enemy's ranks are all around you; one must contend with indifference and sloth; with depression and stupefaction; with long-standing habits; with perverseness, malice, error, blindness; with uncleanness of deed, word, and thought. You are, in fact, encompassed by a large army of evil passions uncontrolled, with all their uncertain and dangerous tendencies, but you are enlisted against them, and so long as you stay in the service, it is your duty to rally your forces and to rout the offenders. Such as cannot be routed must be subjugated and converted into peaceful, law-abiding subjects — no easy task, but who wants an easy victory?

We hear a great deal about the spoils of war, the victor's crown, and the glory of the conqueror on other battle fields. I know the soldiers to whom I am talking, and I believe that most of you are looking for no spoils, no badges of honor, and no glory as of trumpets and drums. I believe that most of you are working for something besides glory, for something besides monthly wages. Even if this latter motive was chiefly what actuated you on entering the service, I think it is otherwise now, though of course no sensible person is indifferent to the compensation he receives for work, and few of us are so situated, or for that matter so philanthropic, as to engage in work of this trying kind without wishing to receive due compensation for services rendered. And, as I said just now, notwithstanding the question of wages was what decided you to take up the work, I think there are few who remain long in the service that do not develop other and higher interests. The average young man or woman with a healthy body, a kind heart, and a helpful disposition, cannot long have the care of these dependent, trying,

often exasperating patients, without developing a tender feeling toward them, and an earnest desire to make up to them, so far as one can, what fate has denied them — a sound mind in a sound body.

I have watched you at your work — a work so arduous and so trying that I have often marveled at the patience and the fortitude displayed in continuing in it, and would still marvel even if your compensation were doubled, and the appreciation of your services more clearly, definitely, and frequently expressed. I have seen you diligent in the business before you, fervent in the spirit of helpfulness to those intrusted to you, showing good will to your associates, and obedience and respect to those in authority. I have seen you perform the most trying tasks a human being could be called upon to do, in comparison with which the cleansing of the Augean stables would be less herculean than some of your daily duties. I have seen you patient under the most malicious abuse, modest in the midst of obscenity, courageous in the midst of discouragements, and brave in the face of hourly dangers before which strong men would quail, and which they would refuse to face a second time. All this and more I have noted, and I make these suggestions, with others that are to follow, not because I underrate your devotion and your self-sacrifice, but because I wish to help those of you who fall short in some of these particulars, and to stimulate and encourage all of you to renewed efforts, to increased usefulness, and to richer results than have hitherto crowned your efforts.

## CHAPTER III

### RULES TO OBSERVE WHEN ON DUTY

EVERY nurse or attendant when on duty must wear the prescribed uniform.

Each nurse is expected to report for duty at the hour designated by the hospital regulations, and to remain on duty continuously until the hour appointed for her release, except when excused either by the supervisor or the physician. A nurse must not absent herself from the ward, unless sent away in the discharge of some duty, without previously obtaining the permission of supervisor or physician. A nurse is not on duty when sitting in her room. During her hours for duty, even if her room is on the ward, her place is with the patients.

One of the first duties of the nurse is bodily cleanliness and tidiness. A nurse whose self-respect is not sufficient to cause her to be fastidiously neat in person and dress, can scarcely hope to inculcate neatness in others. It is not always possible, in doing certain work early in the morning, to be in the immaculate state that all hospital nurses are expected to be in between 10 A.M. and 4 P.M., but it is never permissible for a nurse to come on duty without her body at least being clean and wholesome, and her hair neatly brushed and dressed, even though for the earlier work it is necessary for her to don a uniform not entirely fresh. It is permissible for the nurse to exercise economy in material and in laundry work by thus using her old uniforms when doing certain tasks, but when arrayed for her day's work her gown should be fresh and well mended, however old it may be.

A few words are necessary about the dressing of the hair. A nurse is not dressed in good taste when she has so followed a prevailing mode of hair dressing as to make her cap look like

a ridiculous appendage, instead of, as it should be, the crowning insignia of her office. Dress your hair becomingly always, follow the style in hair dressing (if it suits your face) in so far as you can do so and still have your appearance, with your cap on, what it should be; but if you cannot do this without letting your cap be perched upon your head in an unseemly way which shows it to be there only because it has to be, reserve this elaborate hair dressing until your afternoon or evening out. While on duty, let your hair be neatly and inconspicuously arranged. I was much chagrined once in accompanying a certain president of the Commission in Lunacy through the wards to have him ask me why, as woman physician, I had not influenced some of our nurses to a decent, fitting arrangement of the hair; he instanced one or two, whose hair was dressed in an extreme and unbecoming fashion, as looking like Circassian girls or Feejee Islanders. I could but acknowledge that his criticism was merited. Fancy collars and neckwear, hair ornaments, and jewelry are out of place on a nurse when in uniform. The nurse's pin and the badge on the sleeve are the only ornaments it is permissible for her to wear.

The foot gear of the nurse is an important point for consideration. I believe if all nurses, when on duty, could be persuaded to wear shoes with low, broad heels — and rubber heels at that — and soles of considerable thickness, the ease and comfort thus secured would add to their efficiency, as I know it would to their health and happiness. A nurse with tired feet, with corns and bunions, with tight shoes and thin soles, can never hope to be a good-natured, willing, or efficient nurse. The nurse's shoe should be as much a part of her prescribed uniform as is her gown, cap, or apron, since comfortable foot gear influences the willingness and temper to a surprising degree. Rubber heels, too, aside from the comfort derived from them, secure that noiseless tread so much to be desired in the nurse.

Nurses and attendants are, of course, not to wear or use articles of clothing belonging to the patients or to the hospital, unless, in the latter case, such articles are given them for wear or use by the authorities.

Nurses are expected to set a good example to patients, not only in dress, but in conversation and conduct as well.

The use by nurses or attendants of intoxicating liquors on the premises is a cause for dismissal from the service. It is also against the rules for male attendants to smoke anywhere within doors, except in the places designated for that purpose. It is hardly necessary to say that a female nurse or attendant addicted to the use of alcoholic stimulants or tobacco will scarcely remain long in the institution. While not wishing to discuss the disgusting habit of tobacco chewing, or the silly, disfiguring one of gum chewing, I will merely state that a nurse or an attendant who has so little respect for himself or herself as to indulge in such habits, should at least be taught by the supervisor to respect the patients and the physicians enough to refrain when on duty.

No patient shall be furnished with intoxicating drinks or drugs not prescribed by a medical officer of the institution. Employees are forbidden to deliver to or receive from a patient any letter, parcel, or package, without the consent of a medical officer.

The highest standard of hygienic housekeeping shall be at all times maintained on the wards — visible and invisible cleanliness — a cleanliness that looks after dark corners and upper shelves, a cleanliness that removes the accumulations from behind the radiators and that “sweeps under the mat.”

In connection with cleanliness we may consider the adornment of the wards. The aim of all modern hospitals for the insane is to make the wards and rooms as attractive and home-like as possible; to this end much can be done by the concerted action of the nurses: first, in caring for the property that the State provides, in promptly attending to its repair, in guarding against its destruction by the exercise of systematic foresight; and, in addition to that, in enlisting the interest and coöperation of the patients in beautifying and adorning the wards. Throughout the institution there are many patients who could contribute some of their handiwork. Some can paint, others can embroider stand covers; some can weave very effective mats, and useful and ornamental baskets; some can make rugs, or sofa pillows, or hemstitch bureau covers; others can fashion artistic book shelves, or wall cabinets, or picture frames — these



are only a few of the things, enough to suggest others if you are on the lookout to utilize the dormant capabilities of your patients. By so doing you serve two important ends: you beautify your wards, giving to each its own individuality, and you furnish occupation for the patients. The last consideration cannot be too highly commended, as it may prove one of the most potent means of keeping patients from drifting into demented conditions, devoid of all healthy and enlivening interests. And even if it does not effect this, it will do much to make certain patients feel a personal share in the place which is perhaps destined to be their home the rest of their days.

You can always enlist nature's aid in the adornment of the wards. There are but few times in the year when you cannot find something in the way of decorations that will give a pleasing touch to the rooms and halls. Pussy willows, cat-tails, and the various grasses and evergreens, the wild flowers of spring, summer, and autumn, autumn leaves, wild clematis, bitter-sweet, and alder berries, and many other beautiful berries, can be gathered, and used effectively if taste and thought be given to their arrangement in form and color. These will serve most satisfactorily as decorations, as well as souvenirs of pleasant rambles that you and your patients take when gathering them. There is still another use they serve — they bring the healthy spirit of outdoors nearer to your daily lives. Greenhouses, too, are valuable aids in the adornment of the wards. Requests for decorative plants will usually be willingly granted if you exercise a proper supervision in preventing their destruction. On some wards the nurses say it is no use trying to keep such adornments. I grant that the attempt is sometimes discouraging, but I believe there is no ward where this cannot be effected in time if the nurses in charge are willing to follow the matter up and take a little extra pains to bring it about. For on wards where nurses aver that it cannot be done are patients of the same class as those on other wards where it is done, and where the nurses and patients have learned to take pride in the ward adornment.

Just a word about withered flowers. These are often allowed to remain in the rooms long after their beauty is gone, sometimes from carelessness on the part of the nurse, at others perhaps

from a patient's reluctance to throw away flowers which have been sent her. Nothing is more beautiful than fresh flowers, and few things are more unlovely than withered ones; so remember to keep the water fresh in their receptacles, care for the flowers as well as you can, but when their beauty is gone, quietly consign them to the waste. When decay has set its mark upon them, esthetic and sanitary considerations combine to call for their removal.

While on the subject of disagreeable odors, I wish to emphasize the desirability of having the hospital departments free from bad odors and disagreeable sights, especially at meal time. The hospital wards should, of course, receive careful and systematic attention to ventilation at all times, but especially is it desirable, when patients are eating, that unpleasant odors be reduced to a minimum. In order to effect this, a little foresight is necessary. Unclean patients must be taken up and cared for (and the hospitals carefully aired) long enough before meals to insure against offensive discharges vitiating the atmosphere during the meal hour. The doors to the water sections should be kept closed, patients who are disgusting in habits and mode of eating should be grouped together and, when possible, screened from the sight of others who would be unpleasantly affected by their unsightly ways. Remember that by considering the esthetic feelings of patients you help to preserve these feelings, and thus help to prevent your charges from drifting into the deplorable condition in which this sense is abolished.

It is in the highest degree desirable also to avoid unnecessary noise on the wards, both by day and night. There are many ways in which the nurse can reduce noise on the wards if she will. In the first place, by wearing rubber heels and cultivating a noiseless tread. A sensitive patient during convalescence once spoke as follows concerning a well-meaning nurse who had been an irritating source of discomfort to the nervous invalid: "I used to feel," she said, "as if her heels were going right through my brain. She would race up and down past my door, shouting her orders, jangling her keys, and pounding her heels till I got to hate the sight and sound of her." The quiet turning of the key in the locks, the avoidance of unnecessary jangling of chain

and keys, the gentle closing of doors and windows, the prompt attention to bells (telephone, door, and waiter bells), so that they need not keep on ringing, the oiling of creaking hinges, the attention to flapping window shades, the avoidance of rattling trays and dishes, the careful moving of beds when necessary to move them, the low and gentle voice cultivated by each nurse, the avoidance of hurry and bustle even when haste is necessary — these are a few of the things nurses can do to diminish noise on the wards. Noise in itself irritates both nurse and patient, often without either knowing the cause of the discomfort; the irritability induced begets more noise in those whose self-control is weak, and a regular bedlam is established which might have been avoided had a little extra care been exercised in the beginning. Much can be done to diminish the noise of the patients, too. In the first place, we need to keep in mind that noise is misdirected energy — pent-up energy finding an outlet. All nurses have noticed how much noisier patients are on rainy days, when they have had no outdoor exercise, than at other times. With this in mind, it may be seen why efforts should be persistent in the matter of getting every suitable patient out for exercise as long and as often as you can. Energy will then be expended in beneficial muscular activity out of doors, instead of in bickerings and railings within. On days when it is impossible to get the patients out, if they are interested in some kind of exercise on the hall — arm gymnastics, a bean-bag contest, even a pillow fight, or some such thing, the time and trouble will be well repaid; restlessness and irritability will give rise to a pleasant feeling of fatigue, and to general good spirits, perhaps to a little good-natured hilarity, but is not that far preferable to ill-natured bickerings and contentions? Certain patients become noisy not so much from want of exercise as that some one has offended or interfered with them. It is your duty to study your patients, their whims, and their antipathies, seek to obviate dissensions among them by being on hand and preventing the beginnings of quarrels between antagonistic ones. You can, by so doing, nip many a quarrel in the bud, cut short an altercation that would otherwise go on to high words, blows, and dangerous assaults. Helpless and dependent patients should be especially safeguarded



from irascible and violent ones. You are there to quell disturbance, to guard against abuse and violence. When these occur on your wards, it usually shows that the supervision has not been as thorough as it should have been.

Whenever a physician enters a ward, all the nurses and attendants are expected to rise if sitting, and the nurse in charge is to accompany him through the ward, and hold herself in readiness to give information concerning the patients in her care. Should the head nurse not be present or in sight, any nurse in sight should accompany the physician until relieved by a senior or by the charge nurse. A tactful nurse will know when to absent herself from the room and give patient and physician an opportunity to converse alone. Yet she should remain within calling distance in case information is required of her.

A nurse should be conscientiously obedient and loyal to the hospital physicians. If she cannot be so, she had better find employment elsewhere, for even if she does not commit the grave error of criticising the physicians to other nurses, or to the patients, her antagonism and insubordination show themselves in other ways, and her influence for good is thereby greatly impaired. Such a nurse may be tolerated, but is not valued. It is not to her that one goes for an honest statement, it is not in her that one can feel confidence.

The nurses and attendants in each division are under the direction of the supervisor of that division. The supervisors act as agents between the medical officers and the nurses and attendants. Requests and reports should ordinarily be made through the supervisors to the medical officers, and directions, when practicable, transmitted by them from the medical officers to the nurses, concerning the general care of the patients and the management of the wards. Direct communications to the head nurse are often necessary from the visiting physicians (unless the supervisor is particular to time her visits to the wards at the time that the physicians are making their rounds), as many matters arise that require detailed instructions to those in immediate care of the case, which might suffer in the matter of thoroughness, accuracy, and promptness if the instruction were to pass through a third person.

There are certain duties that nurses owe to one another, certain unwritten rules of fairness and kindness that should invariably be observed. Personal neatness and tidiness in your room and with your belongings, and a consideration for the comfort of your associates, will render you an unobjectionable roommate, even if you do not happen to have the qualities of mind and disposition that make you actually congenial and companionable with that particular roommate. This consideration should extend to matters of room arrangement, order, ventilation, scrupulous respect for, and non-interference with, each other's belongings and tastes, regard for the hours of sleep and rest, and your share of contributing to the order and cleanliness of the room.

On the wards, respect for your superior nurse, a willingness to help her and the other nurses in every way that you can, a real sharing of the burdens and a cheerful working together, patience with the weaknesses of fellow-nurses, avoidance of discussing those weaknesses, refusal to gossip about associates or other employees, or patients, or officers, a helpful spirit toward new and inexperienced attendants, and forgiveness toward unfriendly ones, even those that you feel may have willfully wronged you — these are some of the duties you owe to yourself and to one another.

Let your conduct to the patients' relatives and friends be uniformly courteous and considerate. Many of them are very trying, more so even than the patients, but remember that they deserve your forbearance. Often they come to the hospital in fear and trembling, distressed by the thoughts of their friends being in an institution of this character. They are sometimes nervous and apprehensive, some are fussy and unreasonable, others are perhaps haunted by the fear that a similar fate awaits them. Remember that many are full of fears and prejudices, with the old-time ideas that these hospitals are places of detention and cruelty. They are all unaware of modern methods of treating the insane. They will often beg you to be kind to their loved ones as though that were not the rule. Do not let this appeal arouse your indignation at the reflection on yourself that it implies. Of course you mean to be kind, but they do not

always know it; they do not know you; they are harrowed by anxiety, perhaps by false statements or misrepresentations from the patients. Instead of resenting their appeals, do your best to remove their anxiety.

Nurses are not expected to discuss the patient's condition or prospects with the friends or relatives. On no account are they to express an opinion as to the outcome of a case, nor as to when a patient will probably be well enough to go home. Friends will often ask these and other questions, but the nurse's duty is to refer them invariably to the attending physician. A nurse may express hope of improvement, and may tell of good behavior on the part of a patient, or may mention things in which the patient shows an interest; she may offer to furnish a list of needed clothing (which should, however, first be submitted to the supervisor and receive her sanction), but she should, as a rule, confine her conversation to these lines. She is overstepping her rights when she ventures opinions or suggestions to the patients' friends, except such as have been enumerated. We are constantly meeting with this infringement of the rules. The friends, in talking with the physicians later, say, "Why, her nurse said she could go home at such a time," or, "Her nurse said she could see no reason why she is kept here," or, "Her nurse said this or that," often faulty opinions advanced which the physician is in the embarrassing position of having to correct.

Nurses and attendants are not allowed to visit or to hold correspondence with relatives or friends of patients while the patients are in the institution. All letters regarding patients received by nurses are to be referred to one of the medical officers. It is a grave misdemeanor for a nurse or other employee to give to any outsider the information that a given person has been or is confined in the institution. And if the fact is already known, and the nurse or other employee is approached with questions as to the condition or prospects of any patient, the invariable reply should be that it is strictly against the rules to discuss the condition or affairs of any patient. Such replies should be made in a tactful way, at the same time that the inquirer is given to understand that information on these topics can always be obtained by appealing to the officer in charge,

provided the inquirer is one who has a right to such information.

No male employee shall enter or carry keys to parts of the hospital occupied by women, except by permission of the superintendent. But male attendants, workmen, and other employees are from time to time engaged in work on the women's wards and in the hospital departments. A nurse should respect herself and her calling enough to maintain a pleasant but dignified demeanor toward all such outsiders, going about her duties as diligently as though she expected the medical officers on the hall at any minute, watching her patients to see that no unseemly conduct or conversation that she can possibly prevent, takes place, and absolutely refraining from taking such opportunities for social chats with the ones sent there to do certain work.

It is also the duty of nurses and attendants to exercise especial care when men visitors are on the women's wards, and women visitors on men's wards, to prevent if possible any improper exposure, indecent talk or conduct, or chance of any behavior either on the part of patients or visitors that should be prevented. Failure of proper supervision in this matter has sometimes led to unfortunate results. In rare instances injudicious and unscrupulous visitors have been known to leave drugs, stimulants, and dangerous weapons with patients, and in not a few instances scrutiny is necessary to prevent unseemly behavior on the part of visitors as well as of patients.

Nurses who are sent to the storeroom, laundry, or other places on errands, are guilty of violation of the rules, as well as of bad taste, when they loiter around stairways and talk with the employees whom they chance to meet. Persistence in conduct of this kind should be reported to the medical officers by the charge nurse, if her remonstrance prove ineffectual.

All medicines are to be kept locked in the desks or cupboards provided for such purposes, and are to be dispensed regularly and faithfully as directed by the physicians. In no instance is a patient to be permitted to have her medicine in her room and take it as she wishes. This is a direct violation of the rules of the hospital. On no account is a medicine prescribed for one patient

to be given to another whom the nurse considers to be suffering similarly, unless such medicine is directed to be so given by the physician. On no account is a nurse to give medicine to a patient which has been prescribed for a previous similar attack of illness, even though some of it is accessible on the ward, unless the physician sanctions this procedure. On no account is the nurse to fail to give the medicines prescribed, nor shall she allow herself to insinuate or to remark that the medicine does no good, or that the patient does not need the medicine, or that it aggravates the patient's condition. On no account is a nurse to give or to recommend to a patient any wash or salve or hair dye or corn plaster or anything of this nature without the express permission of the physician in charge, or some other medical officer acting in his stead. Except in extreme emergencies a nurse must not give alcoholic stimulants to a patient without a physician's order, and then it should be immediately reported to the physician, since a condition requiring stimulation probably also requires the immediate attention of the physician. In every instance that a patient refuses to take the medicine prescribed, the fact should be reported to the medical officer.

Great care is at all times necessary in watching over the medicines, disinfectants, keys, matches, knives, scissors, and any articles that could be used as weapons. A nurse should make it an invariable rule to try every door or drawer after locking it, so that the action becomes automatic; then she will not be in danger of sometime leaving these places unlocked, when in haste or preoccupied. She must always bear in mind that many things are intrusted to her care which, if unguarded, might be eagerly seized upon by depressed and suicidal, or mischievous or violent patients, whose use of them might result in incalculable harm to themselves or others.

It is the duty of the supervisor to instruct new nurses in all hospital rules, and especially in the matters just mentioned; and it is the duty of the nurse in charge to exercise constant care to see that these instructions are obeyed. Any negligence in the care of the medicines, the knife drawers, the locking of dumb waiter doors or clothes chutes, the care of keys, or any other precautions whereby patients are prevented from harming



themselves or others, should be promptly reported to the supervisor. A nurse in charge, even if only temporarily so, who fails to report such negligence, or who fails to report any attendant or nurse who is guilty of ridiculing or unkindly or cruelly treating a patient, lowers herself to the level of the one committing the offense. Many nurses have a mistaken notion of its being "mean" to report a fellow-nurse for offenses. They do not wish to be classed with those who tell tales. But this is a different matter entirely, and it seems as though any reasonable person ought to be able to see the difference between the rather questionable practice of spying out and reporting mischief and petty misdeeds, and the honorable one of reporting any instance coming to your knowledge of a helpless insane patient being ridiculed, abused, or neglected by one trusted to care for that helpless person. Where does your honorable conduct lie if, by your silence, you join your strength to that of the unscrupulous one, two against one, and that one helpless and incapable perhaps of physically or mentally defending himself? The sooner you divest yourselves of such notions about honor, the sooner you will be more worthy of the trust placed in you.

Mechanical restraint must never be applied without the written permission of one of the medical officers. In an emergency this permission may be first obtained over the telephone, but the nurse must later obtain a written permission for the same, by applying at the office as soon as the patient is in restraint, or, in case the necessity occurs at night and a verbal permission is given, by requesting the written permission early in the morning, if the physician overlooks the rule of sending it to the ward. These reports must also have the nurse's signature, they must distinctly state the nature of the restraint, the time that restraint has been employed, as well as the necessity for its application, and they must be regularly sent to the office for filing.

No patient shall be locked in a room (which constitutes seclusion, if occurring in the daytime) without the written permission of a medical officer, except in unquestionable emergencies, and even then it shall be immediately reported to the physician, with the reason given for the urgency of such a measure. A nurse who locks a patient in a room for certain hours of a day,

taking her out when she thinks the physicians are likely to come on the ward, is guilty of direct violation of the rules and of unpardonable deception besides.

There are countless things to be observed concerning the nurse's conduct toward and her treatment of patients; only a few can be outlined here; others will be mentioned in speaking of the various details of nursing.

The nurse needs to remember at all times that her first duty is the welfare of the patients. I wish to make this point emphatic. Why do we wish the nurse neatly and suitably attired, the wards hygienically conducted, the work systematized, the food properly served, the bathing carefully and considerately managed, the patients taken out for exercise, sent to amusements, and set to work? For the good of the patients. Cleanliness, law and order, system, hygiene — all are to this one end. Think, then, how you fail in the end, if you lose sight of it, so intent are you on the means to the end! To illustrate: It is a rule of the hospital that the wards shall be in order, the patients' daily needs attended to, the nurses properly uniformed, at 10 A.M. Why? Merely for the sake of the medical officers who formally visit at that hour? No; but rather for the good of the patients. Yet many nurses forget the end which should be kept in view, and, in their desire to accomplish all that must be done, often really disregard the good of the patient, or her comfort. I have seen this repeatedly in going in the hospital departments before the regular visiting hour. I have seen patients rudely and unnecessarily exposed while being cared for, others allowed to sit on a commode or closet, insufficiently clad, in cold weather, and I have seen patients' beds jerked about in a way that would seriously disturb a well person — so intent was the nurse on hurrying to get her work done by the time for "rounds." Another instance of overlooking the end to be attained is where a patient is set to work, perhaps in the sewing room or laundry, and proving herself excellent help, is kept there morning and afternoon, regardless of the need of rest, or of being taken out for exercise, or of going to amusements, if such occur in the daytime. This you will readily see is all wrong, yet such thoughtlessness or mismanagement is discovered from time to time. We wish a

given patient to work because it is good for him or her; that is the primary reason. The work to be accomplished should always be a subordinate consideration; it should never become so prominent that other means of benefiting the patient are lost sight of. Patients shall not be employed on private work for employees without the consent of a medical officer, and no employee is allowed to trade or bargain with patients.

A practice that is reprehensible in the extreme is the habit that some night nurses have, unless closely supervised, of getting their patients up at an unseasonably early hour so that they can get the work done early and secure the help of patients who are perhaps willing workers simply because they are too demented to rebel against being routed out at that hour. This practice cannot be too strongly condemned. The legitimate hour for rising, the hour that has been found necessary by the hospital authorities, is in itself an early one, and no patient should be deprived of the allowance of sleep afforded by the hospital regulations. Even if a patient cannot sleep, she should be permitted to enjoy the rest in bed that is hers by right; and, in acute cases, this robbing her of even five minutes of needed sleep is a really criminal thing on the part of a nurse, for it is jeopardizing the chances of recovery. This question will be discussed further when considering the duties of night nurses and the importance of sleep in the upbuilding of a patient's health.

In some wards I have seen a semblance of order that is all too obviously for the benefit of the visiting physician — an outward order, the floors clean, the beds neatly arranged, the nurses tidy, but the bed patients themselves often bearing evidences of neglect — neglect of some of the details of the toilet. I do not refer to disheveled hair, for I well know that many insane patients will look untidy, though attention is given to them repeatedly during the day and the hour, but I refer to such things as the care of the nostrils, the corners of the eyes, the teeth, the nails (toe nails as well as finger nails), and the care of other parts of the body that we trust the nurse to attend to daily. There is an unmistakable something apparent in certain wards where these details are not systematically attended to; the patients do not look clean, they do not smell clean, they are not



clean. It may be safely argued, too, that if a nurse neglects parts of the body which can be seen, she will be still more negligent of those parts which are only subjected to occasional investigation by the physician.

Patients are to be treated uniformly with respect and kindness. All your dealings with them should be straightforward and truthful; they are not to be wheedled into doing things by false promises, nor frightened into certain lines of conduct by threats of what will befall them if they fail to obey. They must never be ridiculed or teased. You should study your patients as individuals, seek to learn their needs, encourage them to help themselves and one another, converse with them, draw them out about their tastes and their former interests, but do not ask them searching questions or pry into their history. That is the province of the physician. Do not argue about, ridicule, or discuss their delusions with them. Try to make your wards homelike. Let your patients feel that their rooms are for their comfort. While we wish the rooms to be tidy, it is not at all desirable that they preserve that "picked up" appearance that strikes a chill of desolation to one's very marrow, as though one took no comfort in them, and the rooms were on dress parade from morning till night. Let the books and papers and the work of the patients lie around the room in an orderly disorder, if we may so speak, let patients lie on their beds if they wish a nap, or wish to rest; that is what beds are for, although, of course, reasonable care should be exercised in keeping counterpanes clean, and in training the patients to make the beds tidy after having risen from them, so that the rooms do not present a disorderly appearance. Let patients close their doors (when they are to be trusted) if, at times, they desire a little seclusion and quiet, but see that the doors are left open at the hours when the physicians are expected to make regular rounds. In short, allow patients all the liberty possible consistent with safety and with the rules of the institution.

Pay especial attention to new patients and to those recently transferred from other wards. Seek to make them feel at home; explain the rules and customs in vogue in your department.

Maintain vigilance toward those who are depressed and sui-

cidal, and those likely to attempt escape, but do this without letting them feel that you are watching them. Too obvious surveillance is irksome and unnecessary.

Be attentive to the needs of your patients in the matter of clothing and belongings, adapt the changes to changes in the weather, remember that poorly nourished persons need to be more warmly clad and require warmer quarters in the dormitories and hospital departments than the robust ones.

Every ward patient should be bathed at least twice a week and oftener if necessary, and every bed patient in the hospital departments should receive a daily sponge or spray bath. The underwear of every patient shall be changed once a week and oftener, as necessary.

It is the duty of the nurse in charge to see, or to have her assistants see, that all her patients attend daily and regularly to the bowels and bladder, to the brushing of their teeth, and to the scrupulous cleanliness of their persons. If they are incapable of attending to these things, it becomes the nurse's duty to look after them regularly. I do not mean, of course, that the charge nurse shall give each patient in her service her personal attention in these matters, but that she shall assign the care of each patient to some of her helpers whose duty it is to look after these particulars.

Male patients who do not wear a full beard require shaving at least once a week, and the beard, mustaches, and hair must be kept clean and neatly trimmed.

On no account is a patient to be deprived of her meals unless so ordered by the physician. The utmost care should be exercised in serving the meals both in the dining rooms and on the trays; to see that the food is served temptingly; that the individual needs and preferences of the patients are supplied as far as possible; that the special diets reach the ones for whom they are prescribed; also that the changes made in diet are promptly recorded on the diet lists; and that transfers of special diets are effected when the transfer of the patient is made to another ward.

Nurses must not receive visitors on the wards without permission, neither may they go to any ward, other than the one to

which they are detailed, without permission from the charge nurse, or supervisor, or one of the medical officers.

Cooking is to be done only in the kitchen and washing only in the laundry, except by special permission of a medical officer.

All complaints of illness or injury should be promptly reported to a medical officer. Serious illness, injury, or unusual excitement or disturbance occurring at night should be reported to the ward physician or to one acting in his stead.

In all cases of violence, struggle, or resistance, call sufficient help to admit of handling the patient so as to avoid bruising or injuring him.

Nurses must wear their keys out of sight and out of reach of the patients.

Nurses must never give their keys into the keeping of another person, and on leaving the premises must deposit their keys in the place arranged for them, and call for them in person on their return.

Nurses are on duty when accompanying patients to chapel or to entertainments, and when out for exercise, as much as when on the wards, and at such times should make their first object the care and pleasure of their charges. When accompanying patients who are employed in some work, it is the duty of nurses to assist and direct such work, and not to stand or sit idly by and order the patients about.

The conduct of certain attendants at amusements is often gravely criticisable. The rude behavior occasionally noted could never take place if each attendant kept in mind the duty of setting a good example to the patients. It is an actual fact that patients often set good examples to the attendants by their courteous attention and their appreciative applause. It is only rarely that the patients whisper or titter or do anything to annoy others who are trying to listen to recitations, singing, or other efforts to entertain the audience.

In cold weather, when taking patients out for exercise, it is incumbent upon the nurses to see that the patients are properly clad, and in severe weather it is very important to have a care that patients do not freeze the nose or ears or get the fingers frost-bitten.

## CHAPTER IV

### THE RECEPTION OF PATIENTS

IT is a matter of great importance to establish a good first impression upon each patient admitted to the institution. I wish the importance of this could be felt more keenly by all who have to do with each case — by the ushers who greet the patient at the main entrance, by the physician who receives him, by the supervisor who conducts him to the ward, and by each nurse who comes in contact with him as he enters upon his strange life within our walls.

Reflect how often patients arrive after having been deceived by their friends — and even in some instances by physicians — led to think they were going to a boarding place in the country, or to a sanitarium, and consequently, when undeceived, starting in their life here in a state of distrust toward their best friends — the ones they have confided in heretofore. Is it any wonder that they look upon everything they encounter in their new life with suspicion? Or if, as it always should be, the truth has been told them as to their destination, think how many come unwillingly, even resistingly, and full of morbid suspicions and forebodings! Without proper insight into their own condition, many are incapable of understanding the necessity for such a step, and naturally rebel against it. Others whose insight is such that they acquiesce in coming, nevertheless come with dread, with fear and trembling, though knowing that it is the last resort left them.

Much can be done, at the outset, to undo the effects of the deception that has been practiced upon patients, and to allay their natural suspicions and fears.

Remember the lasting power of first impressions; let your first thought be to make the patients feel that they have fallen

among friends, and remember that in just the degree you cause them to feel that we are here to help them, in just that degree is their confidence in the institution gained, and their progress toward recovery furthered, or their condition rendered more endurable if, unhappily, they are cases which will require homes here for life.

The motto which has been over the entrance to the men's wards of one institution for many years should be the guiding principle in our treatment of the insane—"Put Yourself in His Place." If you are endowed by nature with that divinely human quality, sympathy, you will need no better instructor to tell you what to do in each case; but if this quality is deficient or dormant in you, you need to be all the more on your guard, making up what you lack in spontaneous sympathy by painstaking efforts to observe the Golden Rule in dealing with each patient. Most of us are kind at heart, but we are too often absorbed in our own affairs and projects, and forget to look at things from the point of view of others; we take the fact of a patient's coming as a matter of course, and while we are sorry for him and mean to do our duty by him, too often we forget to show our sympathy in tone and manner as we greet him.

I am sorry to confess it, but I have seen new patients welcomed (?) in a way that would strike a chill to a normal, healthy person, to say nothing of the effect upon a sensitive mental invalid. I have heard the words, "What! *You* back again!" uttered in a most unfeeling tone, when the very fact that the person had to return should have entitled her to a warm hand clasp and a spontaneous exhibition of sympathy. I have seen the new patient eyed askance, or even openly stared at from head to foot in a way that made me wonder if the starrer possessed a particle of womanly feeling. I am inclined to think that the sympathy is often really there, though unexpressed, but that a certain failure to put one's self in the place of the new patient effectually prevents it from coming to the surface, so that one sees instead only an expression that seems to say, "Another lot of clothes to be looked over and marked!" "Another troublesome person to be cared for!" Not a vestige of fellow-feeling visible in word or expression! Depend upon it, if you greet a



new patient this way, the impression you create is far more indelible than the ink you use to mark that patient's belongings. Long after your careful efforts in this direction have become faded by the sun and by repeated trips to the laundry, the unfavorable impression you made on the patient's mind will last.

Please do not gather that I wish you to be effusive in your greeting of the patient. Nothing is more to be shunned than the fawning and palaver which an insincere person indulges in for the sake of impressing the lookers-on; this is not sympathy, it is gush; it deceives no one but the one employing it. What I am advocating is a quiet, gentle greeting in a few words, always calling the patient by name, a greeting that shows the newcomer by look and tone that you want to help her and that, sad as is her condition, she has fallen among friends.

When you ask the new patient to accompany you from the office to the wards, call her by name, request that she bid good-by to her friends there and come with you. Explain to her that you would like to see how much she weighs, help her on and off the scales, and if she is feeble, give her your arm to lean on as you go to the ward. If she is very weak or feeble, send for male attendants to carry her, explaining to her, if she is capable of appreciating the explanation, that you will do so to save her from further efforts, since she is tired from her journey. If she is resistive, do not pull her, or attempt to force her; try soothing and persuasion first, and only resort to force if all other legitimate means fail. Even then, exercise great care not to handle her roughly or inconsiderately.

I wish to urge the necessity for greater accuracy in the taking of the height and the weight on admission. These requirements are made for scientific purposes; they are valueless unless accurately taken and accurately recorded. I have not infrequently found a discrepancy of six or more inches in the recording of a patient's actual height — a discovery that has made me infer that the one to whom this duty was intrusted was either inefficient, or, what is worse, negligent, and has attempted to cover up the negligence by a rough guess that has fallen wide of the mark. Accuracy in taking these conditions must of course be supplemented by a painstaking recording of them — the figures



made so distinctly that no possible misreading can occur in the copying. The weight record in every instance should state whether the patient was dressed, or only in her night clothes. This rule should also be observed in the subsequent monthly weight records. Otherwise time and labor are thrown away. Not infrequently a patient who, when admitted, is weighed with all her clothing on, is then put into the hospital department for a month, and, consequently, the next weight is taken in her nightgown; by reason of this, a falling off of several pounds appears in her weight record, with nothing to indicate that the diminution is due to the difference in clothing — the natural inference being that the patient has lost weight, whereas in many instances there has been an actual gain, but with no means of determining it so long as misleading methods are used.

Accuracy is likewise essential in taking and recording the temperature, the pulse, and the respiration on admission. And this means *on admission*, it does not mean the day after. It is inexcusable to neglect this duty on the ground that there appear to be no departures from the normal. As a rule the temperature should be taken in the mouth on admission, but wherever taken, it should be stated whether in the mouth, the axilla, or the rectum. The necessity for this can readily be understood, as these duties in a given case devolve upon various nurses from time to time, and unless a temperature is taken uniformly, variations will show on the chart that are not due to the fluctuations of the disease, but to the lack of system on the part of the nurse. For absolute accuracy it is necessary that the temperature be taken in the rectum. But this is hardly feasible, and as a rule not advisable, on admission. After the patient has become more accustomed to the life here, however, if for any reason it becomes necessary to take the temperature for special investigations, rectal temperature should be ascertained, after explaining to the patient what you are about to do, and why, and that it cannot hurt her in any way. Forestall fears and suspicions by explanations, thereby rendering the patient comfortable and tractable at the same time.

In order to insure accuracy, the pulse should be taken a full minute, and the process repeated in case any unusual rate is

noted, or in case the nurse is inexperienced in this procedure. It should be stated whether the patient is sitting or lying down at the time the pulse is taken.

The respiration observations also require great care. Calm the patient, if possible, and endeavor to observe the speed of the respiration when she is not aware of your doing so. A good method is to keep your hand on the wrist, letting her think it is the pulse you are interested in, instead of the respiration, as one unconsciously alters the respiratory rate when one knows it to be under observation. If there is great acceleration in the breathing, state in your report whether it appears to you to be the result of some diseased condition (any chest symptoms, such as cough, pain, etc.), or whether of exhaustion, or of excitement, such as fright, anxiety, or struggling.

You are expected, too, to note and report any unusual appearance of the body — emaciation, obesity, growths, birthmarks, injuries, bruises, scars, vermin, bedsores, swellings, wastings, eruptions, malformations, dislocations, fractures, sprains, paralyses, etc. Also impairment of motion of any part of the body, or any disturbance of function that you may discover. In short, let your inspection of each case be so thorough and accurate that your report of it will gratify and surprise the physician as to your capability as an observer. Yet all this must be done while bathing the patient, done quietly and unostentatiously, so that the newcomer is not aware of the scrutiny which you are exercising. Patients often resent observation by nurses, thinking it mere idle curiosity, even when willing to submit later to a thorough examination by the physician. Be especially careful to avoid wounding the feelings of those who have unsightly birthmarks or deformities. They are likely to be morbidly sensitive over these things, and you cannot be too considerate of their feelings in this particular. You will remember that the ward admission blank calls for the condition of the person in regard to certain things already enumerated, and in addition, the enumeration of the clothing, and the articles found on the person.

Any striking tendencies, as well as the height, weight, pulse, temperature, and respiration, may also be recorded on this blank,

which should be signed and promptly sent to the office of the physician in whose service the patient is located.

In addition to this record, the nurse in charge, or some one she details for the purpose, should keep a daily description of the patient's behavior for about two weeks after admission, this record to be daily submitted to the attending physician. In this account do not merely say that the patient is quiet or noisy, idle or active, resistive, destructive, and the like. So far as possible, avoid the use of these worn-out terms; be specific by telling just how the patient acts and talks, what she does and says, and what she expresses; how her emotions show themselves, how she spends her time — in other words, give a picture of the case so vivid that one reading it can gain a fair idea of the actual manifestations you have observed. Thus will your notes be valuable adjuncts to the record of the case.

Many patients arrive at the hospital suffering from the fatigue and excitement of a long journey, in addition to the nervous strain caused by apprehension at being put in a hospital of this character. Some of them, too, have been refusing food for days previous to admission, some have been deprived of sleep, some are under the influence of drugs or stimulants that have been administered just before taking the journey — these and many other causes may serve to exhaust the new patient. Your first duty after making her feel that she is among friends, though in a strange place, is to offer her some simple nourishment — a dainty piece of bread and butter, and a glass of water, a cup of hot or cold milk, or with old ladies, especially, a cup of tea. These, offered graciously and as temptingly as possible, on a small tray, with a napkin, will contribute to the bodily needs, at the same time that they cheer and refresh the spirit. See that this simple refreshment is brought as a surprise to tempt the appetite instead of telling the patient beforehand that you are going to get her something to eat.

As a rule it is well, instead of immediately ushering a patient into the sitting-room of the ward, to be stared at by the assembled groups, or into the hospital department where the sights unusual to her would distract and perhaps terrify her, to usher her quietly into a room by herself — your own room would be as

free from interruption as any — and there, while removing her wraps and reassuring her as to the people and the surroundings, let her gradually grow accustomed to you and to the strange life upon which she is entering. In this room the nourishment can best be administered, and here, as a rule, the bodily condition taken.

The nourishment being attended to, the condition of the pulse, temperature, and respiration taken, immediately recorded (and promptly reported to the physician, if it is very abnormal), your next duty is to administer the bath. And here I must urge the utmost care and delicacy. Exhausted patients should be given a sponge bath while lying in bed, protected by screens from unnecessary exposure — not only that, but protected as far as possible from exposure of any part except the one being bathed at the time.

Patients whose condition warrants it should be given a warm tub bath, finishing off with a gentle lukewarm shower bath, care being taken to explain in every case what is to be done, so as not to give a shock to the nervous system.

You need to bear in mind that many patients received here have never been in a bath tub, much less under a spray, and be considerate of their natural apprehension concerning these things. Do not scorn, ridicule, or slight their fears, but try to appreciate and to allay them. Explain to each patient that the rules require that every one be given a bath on admission. Some may urge that they had one that very day. Tactfully make clear to them that the bath will rest and refresh them by removing the dust of travel, and by its soothing effect will help them to sleep better. Other patients will tell you that they don't believe in baths; do not treat this statement with ridicule or contempt, but in your most ingratiating manner set forth the delights of a bath and how much better they will feel afterward. You will by so doing make them willing converts instead of rebellious subjects. The impression that this first bath makes on them will often determine their attitude toward subsequent ones; a little extra pains at this time on your part will be time well spent, even if there were no higher motive considered than your own ease in the future. A shampoo should also as a rule be given with this first bath,

and while I cannot here go into the details to be observed in the bathing of patients, I want to caution you, when washing the head, hair, and face, always to be on your guard that no soap-suds trickle down from the hair to the eyes. I have seen patients with bloodshot eyes the morning after admission, and have heard their just complaints of a careless attendant who allowed this to happen. It is often inattention to some such thing that makes a patient dread the bath — as the burnt child dreads the fire. I believe in the majority of cases, if the nurses are painstaking enough, they can so administer the first bath that the patients will submit willingly in the future.

All patients' heads, bodies, and clothing should be carefully examined for vermin on admission, but this can usually be done in such a way that the patient does not know what is being done.

Above all things, be as careful of your patient's feelings in administering her bath as you would wish others to be of yours under similar circumstances. Think at the start what violence is done to a woman's modesty in submitting to being bathed by another if she has not been accustomed to it; many women come here whose bodies have not since childhood been exposed to the sight of a fellow-being. Remember this, and respect the natural shrinking from exposure that every modest woman feels at having to undergo such a trial. Let your own delicacy teach you how to refrain from giving offense, and how to make the ordeal as easy as possible for your patients. Remember that an insane person has not of necessity lost her modesty. Permit no more nurses in the room than are necessary for safety in a given case. Your daily work in this line makes you accept as a matter of course what is to the patient a real trial. Never allow yourselves to get hardened in this particular.

In cases where the patient is irrational and violent it is different. Explanations are then as a rule useless, and you may need the help of three or more nurses, but always be as gentle, patient, and conciliatory as possible. Even the most irrational patients receive and retain vivid impressions of the treatment received on admission, when to all appearance they were oblivious of what was happening. Their acute and graphic comments on recovery concerning the reception given them are often deplor-



able evidences of the carelessness or the unfeelingness of the attendant from whom they should have received sympathetic treatment.

Remember, too, that if a patient is so far alienated from the normal that she has lost her native modesty, it is your duty to seek to restore her sense of it by taking extra pains to act as though you thought she still possessed it. A good rule to observe in all your dealings with the insane is this: Treat a patient as though you believed her to be what she really ought to be. By so doing you reform her as far as possible.

A patient's clothing and belongings on admission should be searched for concealed weapons, matches, medicines, money, or other valuables, the same promptly turned over to the supervisor and recorded on the blanks furnished for the purpose.

Another important thing to be observed soon after the patient is admitted is a careful explanation to her of the principal rules and customs of the institution. If you can make patients understand that the various things required of them are because of established rules which have been found necessary in the main, and not because of your own arbitrary dictation, they will conform much more willingly, and will not be as likely to chafe under the requirements as they will if they think you tell them to do this or that, to go here or there, merely because you say so.

Tell them what the custom is in regard to the marking and listing of clothing and belongings, explain that this of necessity takes time, that meanwhile they will need to put on some clothing provided for such occasions; that any valuables in their possession, and their money, will be placed in the safe in the steward's office, and that their money can be had on application to the supervisor as needed. Let them understand that they have in the supervisor a friend who will look after the prompt delivery of their belongings, who will investigate any failure of these things to return from the laundry, and who will make requisitions for their needs in the way of new clothing and the like, whenever these needs arise. All these and other rules, so well known to you, necessitate careful explanation to *each new case*. Such explanations at the start will often obviate the not unnatural belief that they are being maltreated, defrauded, robbed.



Let me repeat, allay fears and suspicions that already exist, but guard against their arising, if possible, by painstaking, kindly explanations. Treat patients like reasonable beings, entitled to elucidation concerning the strange conditions they are entering upon. They are more susceptible to reason than you sometimes give them credit for being. The cases are comparatively few in which a nurse's honest endeavors to explain these matters under discussion will not be appreciated and, in part at least, understood. Even if the patient does not always comprehend fully, she is likely to gather that you are friendly and conciliatory, and this is much better than to have her gather that she is a helpless being in your power, forced to do this and that like a dumb beast at the mercy of your dictation, simply because she has been committed as insane.

Tell the new patient the hours for meals, show her where the dining room is, and the location of other places on the hall — the sitting room, the drinking water, the water section. If she is to sleep in a room with another patient, forestall any fears she may have as to that patient by seeking to put the roommates on friendly terms; tell her, if she is to room on the hall, that a night nurse will make the rounds once an hour and that she can ask for anything she needs at such times. If she is put in a hospital department, it will go far toward reconciling her to being in a room with so many others if you explain that until we are familiar with her needs, we will give her a bed in the large room with other patients, where she can have the services of nurses at all times of day and night. Never lose sight of the natural apprehension that any one would feel at being locked in for the first time on the wards of an institution of this kind, and spare no pains to quiet such fears.

Attention to the bowels and bladder of all new cases is very important. Report conditions of impaction and distension immediately. Patients who are excited or exhausted or in a stupor need especial care to guard against an over-distended bladder. A specimen of the twenty-four hours' amount of urine should be sent to the laboratory as soon as possible, accompanied by the patient's name and ward location, the date, and a statement as to the total amount voided in twenty-four hours.

New patients are not to be set to work, nor taken out for exercise, nor to chapel, until the attending physician has consented to it. Do not, however, neglect to call the doctor's attention to these matters if he forgets to speak of it after a few days, especially in persons whose bodily condition appears to admit of these recreations.

The rules concerning letter writing, postage, correspondence with relatives, and concerning the receiving of visitors, should be made clear to new arrivals at an early date. Let every patient feel that in the event of not having stationery of her own, she can, when she wishes to write to her relatives, have some which is provided for just such purposes, and that in the absence of pin money for postage, a stamp will be placed upon her letter in the office. Patients who can afford to supply themselves with these conveniences should be encouraged to make known their needs in letters to their friends, but those who cannot afford this should never be made to feel that a reasonable amount of stationery is withheld or given grudgingly. All persons whose mental and physical condition admits of it should be encouraged to write to some relative once in two or three weeks, at least, in order to keep alive a healthy interest in home life and in the world at large. Some patients will, of course, wish to write as often as once a week, and some need to be restrained from daily letters, but such cases should be reported to the physician whose duty it is to regulate these matters. On no account is a letter written by a patient to be withheld or destroyed by the nurse, however illegible or irrational it may be. Indolent and indifferent patients need frequent reminders to write to their friends.

Tact is requisite in explaining the necessity for leaving outgoing letters unsealed that they may be examined in the office, if necessary, by the physician. But it should also be stated that their letters from their friends may come to them unopened. A patient capable of writing letters can, as a rule, be made to see the necessity for leaving outgoing letters unsealed, distasteful as it may be to do so. A sensitive person naturally writes under constraint when knowing that the writing may fall under the eyes of another than the one to whom the letter is addressed, even though no secrecy is contained therein. While this is unavoid-

able to a certain extent, patients should be made to feel that only the doctor in charge has the right to read the letters they write, and that he will see to their being sealed and sent as soon as they are examined, if found suitable for sending through the mails. The patient has the right, and it should be clearly made known to her by the supervisor that she has this right, to put her letters directly into the hands of the supervisor, whose duty it is to convey them promptly and inviolate to the physician. A nurse who interferes, or reads a communication of a patient, unless urged to do so by the patient, is guilty of a grave misdemeanor. It ought not to be necessary to mention this fact, and I would not, were it not that prying nurses have from time to time made a point of reading patients' letters, and unprincipled ones have even transgressed their rights to the extent of intimidating the patients if they wrote certain facts to their friends; still others have so influenced patients as to inspire them to send out fawning and high-colored eulogies of the nurses in question. Such conduct is inexcusable and unscrupulous, and is, of course, beneath the practice of any high-minded person.

There are cases, it may be stated, where the patients can only be induced to write letters under the encouraging supervision of the nurse, and many a patient's friend has been cheered by a letter which cost the nurse literally hours of coaxing and persuasion before its completion could be effected. Such instances, it is hardly necessary to say, do not come under the criticism I have just made. But even in these cases, do not tell the patient what to write. Suggest, if he actually needs suggestion, that he tell about the place, his room and surroundings generally, the entertainments he has attended, and the like, but do not try in the remotest way to keep him from telling anything that he wants to tell of what impression the place makes upon him, or of what treatment he has received here. Let your concern be to keep the treatment such, so far as you and the nurses under you are concerned, that you will have no reason to fear the truth, and if he distorts the truth, or tells absolute falsehoods, you still have nothing to fear, for if you are innocent, you will welcome any investigations that may be made concerning these accusations. If you see that he has used obscenity or profanity in his letter,

you may tell him that the doctors will be unable to send such a letter through the mail, but if he does not willingly erase it, turn the letter over as usual to the proper authorities. If you learn that a patient has written to his friends that such and such a patient is here, giving name and residence of a given patient, try to persuade him that it would be kinder to refrain from mentioning such fact, on the ground that he would not like to have the news of his being here circulated among his friends, and consequently should forbear spreading news in regard to others.

So long as the opinion obtains among people at large that mental diseases carry with them a certain stigma, just so long will people be sensitive about being cared for in hospitals for the insane, and while nurses should do all that they can, directly and indirectly, to lead people to a more enlightened view of insanity as a disease, not a disgrace, still they are in duty bound to respect the natural reluctance patients and their friends have toward spreading the knowledge that a given person has been or is thus afflicted.

The patient's name and the ward on which he is located should be placed on the inside of the lapel of each outgoing letter. As a matter of fact, many a letter written by patients who the physician knows can be trusted not to resort to connivance, or obscenity, or profanity, is permitted to go to the friends without examination in the office; but unless exceptions are made by the physician in a given case, all letters should be sent to the office unsealed.

I wish to remind you of the extreme care necessary in dealing with violent and resistive cases. When force is necessary, let it be quietly and firmly administered, by marshaling sufficient help so that the struggling patient sees the uselessness of further resistance. But let the nurse first control herself if she would control her patient — control voice, hands, manner. Do not scream at, scold, threaten, or ridicule a patient, whatever the provocation. On no account threaten a patient with seclusion, or with the safety sheet, or with a bath. It is a nurse's fault, and a grave one, if the patient ever gets the notion that baths or packs are administered as a means of punishment. Nor should the slightest appearance of "discipline" ever enter into the



administration of a bath of any kind, or the application of a safety sheet, or a pack, or seclusion. Patients should be made to understand that restraining measures are of necessity adopted on occasion because they are unable to control themselves — that we do it reluctantly, and only for the purpose of protecting them, or others, or to prevent wanton destruction of property, etc.

Preserve the patient's self-respect by treating him as a rational human being when he is in the faintest degree capable of reasoning. When incapable, treat him kindly, considerately, as a patient mother would treat a wayward child, not as a rough uncultured person would order about a dumb animal, or a stupid servant. It is only a narrow-minded and an ill-bred person that will exercise petty authority over helpless beings intrusted to his care. A refined nature will show by sympathy, by kind glances, and by forbearance with trying peculiarities and whims, that the wish and the intention are always to aid troublesome charges — to improve them, to guide, but never to "boss" them.

Never command or coerce when you can persuade. When coercion is imperative, do not let temper or resentment enter into word or manner; and, whenever practicable, explain to the patient that it is with extreme reluctance that you force him to do a given thing, that it is only because you must carry out the doctor's order; and tell him that you much prefer that he do it voluntarily. This will result in many instances in the patient's yielding, though reluctantly, rather than submit to force. The mildest power is indeed the most potent, and a tactful request more efficacious than a rude or brutal command.

Take pains to introduce the new patient by name to the other nurses, to each doctor as he visits the ward, and to some of the more congenial patients around him. Use the titles, Mr., Mrs., or Miss, before names, or, if the patient is very young, he may be called by his given name. On no account are women patients to be spoken of by their last names among the nurses, and no nicknames are to be used.

In a few instances, where a patient's delusional state is such that he makes homicidal attempts on one who addresses him by his real name, we find it wise to make exceptions and cater to

the whim, avoiding the use of the name that gives rise to such dangerous exhibitions of temper. Such exceptions are, however, to be decided by the physicians.

As already urged, respect each patient's individuality, let him feel that he is a factor in the life of the ward, that he counts for something, that he is not lost or swallowed up in that heterogeneous mass, "the patients," but that, so far as lies in your power, his comfort shall be considered, his interests made your interests, and his progress toward recovery aided. Courtesy begets courtesy. Make your patients feel that we are not lost to all social observances simply because we live in a hospital for the insane.

There are those of you who would not think of neglecting the proper ventilation of the ward, the nickel trimmings of your water faucets, the polishing of your floors, the immaculate order of your clothes rooms, the bathing of your patients, or the attention to any of their temporal wants — such neglect would be inexcusable in your eyes, whether in yourselves or others. Are you just as careful to minister to the delicate sensibilities of these nervous and mental invalids? Do you always try to maintain a cheery, tranquil moral atmosphere on the wards, and are you on the lookout to let fall the kindly glance and soothing word that may brighten the despondent souls and warm the lonely hearts of patients in your care?

Let your faithfulness extend to these things also, if you would truly minister to their diseased minds.



## CHAPTER V

### WARD MANAGEMENT AND DUTIES OF CHARGE NURSE

THE general management of the ward devolves upon the nurse in charge, who should, of course, be carefully trained and self-disciplined. It is she who is responsible for the order and system, or the disorder and lack of system, that there prevail.

“To be in charge,” as Florence Nightingale well said, “is not only to carry out the proper measures yourself, but to see that every one else does so too; to see that no one either willfully or ignorantly thwarts or prevents such measures. It is neither to do everything yourself, nor to appoint a number of people to each duty, but to insure that each one does that duty to which he is appointed.”

This organized system of each nurse's regular attendance to her own duties is what constitutes a well-managed ward. A head nurse may be ever so faithful in doing the work she assigns herself to do, but unless she also sees to it that her assistants do theirs equally well, she is derelict in duty, and only half fulfills the responsibilities of her position. Any failure to perform duties properly, any carelessness or inefficiency on the part of her assistants, is something that the nurse in charge is directly responsible for, unless, failing in bringing about desired results, she promptly reports the delinquent to the supervisor, who should, in turn, as promptly report to the visiting physician. It is inexcusable in a charge nurse, on her attention being called to the negligence or inefficiency of an assistant, to offer the excuse, “Yes, I know, but I can't do everything.” It is not expected that she do everything — that is just the point; but it is expected that her ward work shall be so systematized that each nurse and attendant knows definitely what is required of her, and failure to do this should be ascertained by the one whose duty it is to hold each assistant

to the fulfillment of her prescribed tasks. She should never do the work assigned to an assistant except in case of emergency. To do that is to destroy her discipline and render a careless attendant more careless.

The nurse in charge is there to exercise a wise guidance and supervision of the ward at all times, and not only that, but to have such order and system prevail, by reason of her attention, training, and instruction, that affairs will be properly conducted even in her absence. One occasionally sees a charge nurse so vain that she wants to be missed, she seems almost pleased if things go at "sixes and sevens" in her absence, thinking that her qualities will shine the brighter in comparison. This is a palpable fallacy. A ward that is well managed — one in which each nurse does her work from a sense of duty, regularly and faithfully, one in which the nurse in charge is such a power for good that her own qualities are caught and imitated by her subordinates — is the ward that will run smoothly even in the absence of the charge nurse. Written directions concerning special matters and special cases should be left by the nurse in charge in her absence from duty.

A spirit of friendliness, a cheery atmosphere, a feeling of unity and helpfulness, these are the things the charge nurse must seek to have prevail in the department over which she has sway. If she has force of character and the executive ability requisite for the proper fulfillment of her position, what she is, or what she is not, is felt in the general atmosphere of the ward. If she is tidy in dress, prompt in coming on duty, exacting in seeing that her assistants do the same, if she is courteous to her associate nurses, respectful to the matron and supervisor, and loyal to the physicians, gentle and thoughtful in her care of the patients, considerate of the patients' friends, and earnest and diligent in seeing that the physicians' instructions are carried out with promptness and fidelity, these things are imitated by her subordinates. What she is, is reflected in the conduct of the other nurses who come under her influence. On the other hand, if she possess just the opposite of these qualities, her influence is as potent for bad as that of the efficient nurse is for good; if she is an eye-servant only, her associate nurses will to a great degree become eye-servants also, except in some rare instances

where conscientiousness and principle are strong enough to prevail even when a poor example is set by one to whom subordinate nurses naturally look for inspiration and guidance.

I like to have a charge nurse consider her relation to her patients something as does a hostess hers to her guests, especially in the hours of comparative leisure when she is on duty, but with no actual work demanding her attention. At such times let her mingle with her patients as among her guests, gracious in manner and thoughtful for the comfort of each one, especially the ones that are timid and retiring. Let me remind you, though, that when I say gracious I do not mean patronizing. Let her bring together those who will be congenial, draw out those whose talents for music, reading, dancing, or recitation would contribute to the pleasure of the company, arrange a quiet game of cards here, perhaps a bean-bag contest somewhere else, and in various ways put her wits to work to interest and amuse her charges. Let the early evening hours be given over to some recreation; plan for these things so that the patients will look forward to the evenings and will bestir themselves in turn to do what they can to contribute to the entertainment. Do not be afraid of music and a little good-natured noise and jollity in the parlors in the evening. A little nonsense, hearty laughter, and a cheerful social time will make all of you sleep the better, and start out the succeeding day in better spirits and with a community of interest that will surely be developed by working and playing harmoniously together.

It is a good plan for the nurses on each ward to organize themselves into a committee of amusement, letting each one be responsible for the amusement of a certain evening. In this way personal interest is stimulated, responsibility is shared, variety is secured, and a wholesome rivalry as to who shall conduct the most successful evenings is established. Sometimes very simple preparations will yield the pleasantest results.

In connection with music on the wards, discretion must be used; there should be temperance in all things, even in music. While it is desirable not to interfere with a patient's liberty in any legitimate amusement any more than is necessary, you will sometimes have to consider the good of the many, even to the

restriction of one person's liberty. Occasionally a patient, unless hindered, will sit at a piano and play and sing, for example, Gospel Hymns from beginning to end, for hours at a time. Perhaps that one patient enjoys such a feat immensely, but you must consider its effect upon the other patients. There are various ways of obviating the annoyance besides locking the piano and arbitrarily prohibiting playing and singing. No nurse has a right to do that; in fact, no one but the physicians may dictate to this extent. If music is objectionable to a nurse, if she has a headache, or is irritated by the efforts of the patients to entertain themselves, and she alone, by reason of her idiosyncrasies is annoyed by it, she should seek the aid of medicines for her headache, if she has one, or perhaps take that opportunity to walk out if the music is merely distasteful to her, or she should "grin and bear it," remembering that the pianos are on the wards for the use of the patients. A tactful nurse will know how to suppress the persistent performance of monotonous music by suggesting that she would like to hear this or that — something of an entirely different nature — or she can sometimes engage the patient in conversation, and so let the piano and the enforced listeners rest, often without the assiduous musician realizing that she is being managed.

In connection with her duties as hostess of the ward over which she presides, the charge nurse will of course receive all visitors standing, greeting them courteously, and showing herself ready to do the honors of the ward, whether these visitors be strangers, physicians, matron, supervisor, or nurses from other wards. And she will so instruct all new assistants at the beginning of their work in her domain that they will readily grow into the spirit of courtesy. If a new attendant is so ignorant of the fitness of things that she remains sitting when a visitor enters the ward, it is a reflection upon the nurse in charge if this breach of etiquette is not corrected soon. Sitting around on radiators and tables is not to be permitted. Attendants prone to such customs must be promptly made to understand the impropriety of such behavior.

Especial care is needed in precept and example on the part of the charge nurse and the senior assistants, in making new attend-

ants familiar with the necessary rules and traditions of the hospital, and in starting them out right, with a proper attitude toward the work. The new helpers, having so much to learn at once, cannot be expected to remember all that is told them with one telling. Furthermore, they are sometimes transferred from one ward to another so rapidly that no regular and continuous instruction is afforded them. Accordingly, it is better in receiving a helper to your ward, unless she has been in the institution for some time, to proceed on the same plan that you would with a new attendant, taking care to use tact in your methods of instruction, asking her if she has been told this and that, and so outlining the essential points of instruction without making her feel that the instruction on other wards, or her grasp of it, has been defective.

Charge nurses should take care to make probationers feel welcome. Too often they are made to feel that it is a trial to receive them for instruction. It does entail extra work, extra responsibility, for all the details of nursing that have become so familiar to trained assistants have to be patiently and frequently explained to the uninitiated. The charge nurse needs to remember that there was a time when she herself was inexperienced and unskilled, perhaps as awkward as the pupil nurse she is now called upon to instruct. It should be her pride and pleasure to see all of her helpers grow in deftness, skill, and efficiency under her tutelage. Of course it is far easier to do difficult things than it is to stand by and laboriously teach pupil nurses to do them; but if she deals justly with her nurses, she will see that they have the opportunities and the guidance necessary to acquire ease and skill in the practical points of nursing, and these can only come from doing them, never from merely standing by and seeing them done.

In order that the entire institution may work in harmony, there must of course be uniformity of system, coöperation between the heads of departments, loyalty to superiors, helpfulness to and consideration for all.

The charge nurse when on duty is expected to accompany the attending physician on his rounds, taking pains to acquaint him fully with the condition of the sick patients, with reports



of new cases, and of happenings of import since his last visit. She should make it a point to be on hand at these times, and it is a good plan for her to keep a small memorandum of things necessary to report, thus making it impossible to offer the excuse for neglect to report important things that one sometimes hears — “It slipped my mind because — was so noisy,” or because such and such a thing happened. It is her duty not to forget, and the habit of keeping a memorandum will aid her in this duty.

She should take down the special directions given by the physician, not trusting to her memory to recall the various things that may arise in the course of the rounds. The list of medicines and the charts, the weight lists, etc., should be at hand for ready reference when the physician is visiting the ward, and there should be kept lists and instructions of patients having regular baths, douches, and special treatment, with the temperatures and other details outlined, the days and hours for treatment, etc., so that in the absence of the charge nurse, the affairs of the ward may go on uninterruptedly.

Some of the requisites for an efficient charge nurse, in addition to executive ability, good breeding, an equable temper, and conscientious and painstaking attention to duty, are the following: She must be a good and economical housekeeper, looking after the State's property and her patients' belongings as carefully as she would after her own. Economy in the use of heat, lights, water, food, and ward supplies in general is an indispensable quality in a charge nurse. She will check useless waste as rigorously as though she were paying for it herself. The State puts this trust in her. Her own self-respect demands careful supervision in these matters.

She should keep a neat, accurate, and up-to-date inventory of all the ward furniture, should see that the ward supplies are kept up, that the linen is in good order, that the medicines are kept carefully locked, and faithfully administered according to directions; that the temperatures, pulses, and respirations are carefully taken and accurately recorded, and likewise the weighing of patients. The proper ventilation of the ward, the maintenance of the required temperature, and the general hygiene



of her department are matters she is directly responsible for. It is especially incumbent upon her that she train her assistant nurses in the careful observation and recording of symptoms, in the giving of enemata, in catheterization, douches, and baths, and in the dressing of wounds and the nursing of special cases. The special diet of patients must also receive her intelligent supervision, and any great variation in weight in a given case, whether it be a loss or gain, should be mentioned to the physician in charge. Also any injury, or assault, or bed sore, or accident, or menstrual disorder, or other complaint or appearance of illness, should be promptly reported to the visiting medical officer, however slight it may seem, and anything of moment should be immediately reported to the office, not waiting for the official visit to take place. So far as possible, nurses in charge should take pains to report happenings or changes on their wards to the physician in immediate charge of that ward, but on failure to find the ward physician, important occurrences should be reported to some other medical officer, while matters of grave and critical moment should be reported to the first physician accessible. On the next visit of the regular visiting physician to the ward, mention should be made to him of important changes which have been temporarily reported to another, even if they have already been attended to in his absence.

The charge nurse must make her assistants feel the importance of her being apprised of all that happens on her ward. No matter is too trivial for her attention. If she has the requisite dignity and tact to make her a success in the position, she can do this without evincing a domineering spirit or arousing the antagonism of subordinate nurses. Sympathy, consideration, and dignity are indispensable qualities in dealing with assistants. While being friendly and helpful, she must never be familiar with nurses or patients. She must let the nurses feel that they have in her a ready instructor, but one who will suffer no breach of discipline and no slighting of duty. She will let them see by her trained observation of generalities and of details that it is difficult to escape her watchful eye. By her own attention to systematic work and to tireless observation of all that makes for order and harmony, she will inculcate order and harmony

in her assistants. She must teach them in season and out of season the necessity of having a place for things and putting them in their respective places, not occasionally, but invariably — a practice that, however troublesome it may seem, is always easier in the end, although it entails considerable self-discipline and patience to bring it about.

The charge nurse needs a large supply of tact and charity. She is in a position where she is frequently forced to correct and rebuke her assistants. To be able to administer a reproof without arousing antagonism and yet have it effectual is often a delicate task; nevertheless it can be done so that the one meriting the criticism will have only respect for the one who gives it. The spirit and the manner in which criticisms are given largely determine the way in which they are received.

All gossiping on the ward is out of place, and the nurse in charge who has a proper appreciation of her duty will neither lower herself by such indulgence, nor permit such conduct on the part of her assistants. Especially to be avoided is the propensity that attendants often show to chatting together in the morning when coming on duty, perhaps harmless gossip in itself about things that have happened to them the night before, or their last time off duty, but entirely out of place here, and not to be permitted on the ward, where their time and attention are required for the duties at hand.

The head nurse will permit no calling down or up dumb waiters to anybody, except the necessary instructions to the waiter boys; she will permit no undue familiarity between patients and nurses, and no loud or unseemly talk or behavior on the part of the nurses under her supervision. She will be held responsible for her nurses and attendants being in the prescribed uniform at all times when on duty.

The head nurse is directly responsible for the proper admission to and discharge of patients from her ward, and for their transfer to other wards, and will not only give these matters her personal attention, but will also see in the case of transfers that the nurse in charge of the ward to which the patient goes is informed of all that is necessary to an intelligent understanding of the case.

She will exercise a special supervision over parole patients,

being on the lookout for indications of oncoming periods of excitement or of depression that would make a withdrawal of their parole advisable.

The needs of patients concerning clothing and accessories to their toilet should receive the care of the nurse in charge. That they receive their mail promptly, and that outgoing letters are promptly sent to the physician's office, should be a matter of her conscientious attention. The recording of the dates and names of visitors, and their relationship to the patient should be systematically attended to, and any conspicuous or interesting feature of the visit, or any marked effect upon the patient, favorable or unfavorable, should be reported to the visiting physician.

All attendants who give promise of developing into good nurses should be encouraged to enter the Training School, and all who do enter should be held to the regular attendance upon lectures, and stimulated to maintain a lively interest both in the lectures and in the practical training on the wards, in the daily attention to the numerous details of their work.

New attendants should be carefully drilled in the use of the ward telephones and in the rules governing the same. They should be taught especially how to ring up and ring off, how to make their requests or to deliver their messages in a calm, clear tone, how to respond to calls, and how to reply to an order given over the 'phone, as a rule repeating any important order, to insure perfect understanding of it, and making sure that the one giving the order, or calling them up, has finished what he wished to say and dismissed them before they hang up the receiver. No visiting or gossip or unnecessary talk is to be permitted over the telephone.

The head nurse is responsible for the proper transmission to night nurses of special instructions concerning new patients, or concerning any special thing, and should require of the night nurse a personal account of any unusual happenings in her department during the night.

Nurses in charge of hospital departments should see that the supplies in the dressing basket are renewed when needed. This basket should contain absorbent cotton, lint, gauze, roller band-

ages of cotton and gauze of various widths, adhesive plaster, scissors, safety pins (large, small, and medium), common pins, needles, white thread, and a thimble and a tape-measure.

While order and system are indispensable in the ward management and in the instruction of assistant nurses, it is especially desirable that unnecessary routine be avoided in dealing with patients. A perfunctory compliance with one's duty is deadening to any alert interest. You must try to get a fresh eye frequently, so that you see in each case a fresh possibility for improvement and encouragement.

Watch for chances to arrest the patient's attention and interest; one thing works in one case, another in another; lead him out of self-absorption by offering a new interest in something, or a new aspect of an old interest. Sometimes a mere trifle works wonders in starting a patient on the road to recovery.

Above all, keep your able-bodied patients occupied at something a goodly portion of each day. A nurse should be ashamed to see or to have seen on her wards a lot of listless, unemployed patients. Much is lacking in her endeavors if this is a customary sight.

Let your patients feel that as charge nurse your greatest pleasure is in giving them pleasure. Be sincere in this. If you are, your patients will feel it, and your influence over them for good will be tenfold greater than it otherwise could be. The awakening of a helpful concern in the life about them, the inculcation of tidiness and of ambition, the direction of employment and of recreation, interest on your part in their reading, in their friends, and in their letters from home, the cultivation of friendly intercourse among themselves, and among the other nurses, the stimulation of interest in outdoor life, all these things have an important bearing on the mental and moral welfare of your patients.

Encourage them to tell you about the books they are reading, about the sermon they have heard, about what they saw out of doors, and about what they themselves feel would contribute to their well-being and recovery. Their ideas, even though lamely expressed, will be suggestive to you, and the expression of them, and your interest in it, will be helpful to them. Cultivate any special gifts or tastes that patients may have, and make them

feel that in this cultivation they are contributing to the enjoyment and well-being of others.

See that your assistant nurses are always mindful of their patients' pleasure at entertainments and dances and during their daily walks, and that the dining-room attendants are especially watchful of their needs at meals.

These duties of the head nurse, as outlined, are arduous in the extreme. Even on the best-managed wards, and with the best-trained assistants, trying and harassing occurrences and experiences will be met, and the head nurse, with so many things for which she is held responsible, will never find her work easy. Vigilance and equanimity, infinite tact and patience, are in constant requisition, but with an intelligent understanding of her duties, and the executive ability without which she cannot hope to succeed, the conscientious and humane nurse will find abundant reward for the faithful discharge of these manifold duties.



## CHAPTER VI

### HYGIENE OF THE WARDS AND OF HOSPITAL DEPARTMENTS

THE ward, or hall, with its sitting room and adjoining rooms arranged for one, two, or more occupants, should be considered as the home of the patients; the hospital departments, or infirmaries, should be regarded as sick rooms. Bearing this distinction in mind, the management of hall and hospital ought to be easily outlined, and, with order and system prevailing, effectively executed.

Let us then consider the management of the ward as regards ventilation, cleanliness, order, and attractiveness, since no place can be truly homelike unless these conditions prevail.

What do we mean by ventilation? We mean to supply fresh air and to remove foul air. Why is it necessary to supply fresh air and to remove foul air? Because air that has once been breathed has been deprived of its building-up qualities and is therefore unfit to be breathed again. We would not think of bathing in water which had already been used for that purpose, because the dust and the worn-out particles that accumulate on the body pass into the water — the very thought of this is repugnant to us, yet many persons think nothing of breathing over and over again, not only the air they themselves have already breathed and so contaminated, but they also breathe over and over the air that has been vitiated by the breaths and the emanations from other persons as well. When we think of it, how much more fastidious we ought to be concerning the purity of the air we take into the lungs than concerning the water which touches the skin, for the contact of the air is so much more intimate, becomes so much more a part of us than does mere surface contamination. When we insult our lungs by giving them impure air to breathe, we are starting a process that is

far-reaching; the blood that is sent to the lungs to be purified is only partly purified — washed in soiled water, as it were — and goes back to the cells of the various tissues with not enough of the up-building qualities to feed and renew the cells; consequently we suffer from the impoverishment. The renewal that nature intends to be going on in every part of us is only a make-believe renewal, and, in time, tissues and organs, body and mind, suffer from the slow starvation of the cells deprived of their requisite amount of nutriment. For waste goes on continually, whether repair succeeds waste or not, and in proportion as these unhygienic conditions prevail, various parts, and, in time, the whole organism, suffer — the parts naturally weakest succumbing earliest, showing, first, disturbances in function, and later, organic disintegration.

We need to consider what the air we breathe is composed of in order to understand what ventilation accomplishes. It is composed of the gases oxygen and nitrogen, with a small amount of carbon dioxide and a variable portion of watery vapor. The air we breathe, or in other words, the atmosphere, is invisible, yet it is all about us. Being invisible, there is no way of telling by the sense of sight whether it is clean and fit to breathe or not. The sense of smell helps us somewhat, as very foul air is heavy and offensive to a healthy and well-trained olfactory sense; but this is too uncertain a guide to depend upon. When we grow sleepy and listless and "headachy," even if the sense of smell has given no warning, it is safe to assume that the oxygen in the air is becoming exhausted, and that we need to furnish an outlet for the air that has been breathed again and again, and give admission to a fresh supply that nature has purified. The gases nitrogen and oxygen mingle together in what is known as fresh air, in the proportion of four parts of nitrogen to one of oxygen. The gas that is most abundant, nitrogen, cannot support life, it is simply used as a diluent or vehicle for the oxygen, and is weak and inert. The part that gives life, that builds up and rejuvenates, that is constantly active, is the oxygen. When fresh air enters the lungs it is rich in oxygen, but this is quickly appropriated by the blood, and the lungs give off or exhale a very different and poisonous gas which is the product

of the worn-out tissues, carbon dioxide. We need to remember the prime necessity for furnishing a continual supply of fresh air for ourselves and for the patients. We need also to remember that in addition to the air we exhale, which is deprived of its oxygen and rendered unfit because of its preponderance of carbon dioxide, there are emanations from the skin and from the expired breath, and odors from the secretions, micro-organisms, vegetable and mineral products, all of which help to vitiate the air. Of course this is even more true of sick than of healthy persons, hence the added reason why hospital departments shall receive extra attention in the matter of regular and systematic ventilation. Stoves, lamps, and gas jets in operation quickly exhaust the fresh air from a room by stealing the oxygen and giving off poisonous gases.

Nature has a wonderful provision for purifying the air, making the animal and vegetable kingdoms contribute to the support of each other, utilizing what is of no value to one for the benefit of the other. Animals need oxygen, and abstract it from the air at the same time that they give off carbon dioxide. Plants need carbon dioxide; it is their food, as oxygen is ours, and they give off oxygen as their waste product through their leaves, which act as lungs. Winds and rain also contribute to the cleansing of the air. Hence we see that a process is going on in nature that is continually purifying the external atmosphere. Now what we need to do is to take advantage of nature's work, and let our homes and hospitals have the benefit of this purification. This is what ventilation does. It is effected by means of doors and windows, fireplaces, chimneys, flues, and other special apparatus provided for the purpose. Ventilation in warm weather is, of course, a simple matter, but when cold weather comes, we have to consider not only supplying the fresh air and letting out the stale air, but also warming the fresh supply, so that rooms are rendered comfortable and hygienic at the same time.

In ventilating one needs to guard against the fallacy that cold air is necessarily pure air, and that warm air is necessarily impure. The temperature has nothing to do with the purity or the impurity of the air. A room which has not been heated

or ventilated for weeks may be filled with cold, stale air unfit to breathe. A ward does not need to be cold and uncomfortable in order to be sanitary. By changing the air frequently and closing up between times, the halls can be kept hygienic as well as comfortable. Fireplaces are the best means of ventilation, but there are few of them in many hospitals, and these few are seldom in use. But even when not in use, if kept open, they furnish an exit for the impure air. A fire in the grate, by causing a constant draught of air to ascend the chimney, and a constant quantity of fresh air to descend as well, is one of the most effective means of ventilation. When special ventilators are in a building, it is the nurse's duty to see that they are always kept open.

The object to be attained in ventilation is to keep air currents in circulation all the time without a draught striking the occupants of the room. In the rooms adjoining the halls, where, as a rule, there is but one window, that window should be open a little way both at the top and bottom during the night and the greater part of the day; not enough to cause a draught, but enough to let the warm, impure air go out at the top and the cold, pure air come in below.

To prevent a draught, a four- or six-inch board may be fitted across the window sill to cover the opening made by raising the lower sash. This admits of the air circulating between the sashes. In rooms with two windows opposite each other, open one from the bottom and the other from the top. Remember that the smaller your rooms are, the greater is the need for frequent ventilation, and that with a large number of people congregated in a given room, the need for frequently supplying them with fresh air is correspondingly great. Rooms which have a transom furnish additional means for ventilation. The rooms into which they open, however, need to have the air changed from time to time.

Halls and sitting rooms are easily ventilated by opening opposite windows, above and below. As a rule, except in severe weather, these may have small openings all the time, care being taken to throw the windows wide open at intervals, and always when patients are at meals, and so admit of a free circulation

and entire change of air. By closing the windows entirely for a while after these thorough airings, the halls soon become warm and comfortable, yet the occupants have a fresh supply of air to draw from. The nurse in charge should train her assistants to see that this change of air in the rooms, halls, and sitting rooms is regularly and systematically attended to. The dining rooms should be thoroughly ventilated by throwing up the windows from the bottom and pulling them down from the top for fifteen or twenty minutes after each meal; then some smaller openings in opposite windows may be maintained nearly all of the time, the windows being closed only in severe weather, long enough before meals to insure the comfortable heating of the room. It is cheerless, and unnecessary, as a rule, to have to eat in a cold dining room.

In summer, attention should be paid to keeping the dining rooms darkened and cool by drawing the shades and having the windows opened to their limit between meals, but when at meals, the shades should be raised and the room made as attractive as cleanliness, fresh air, sunlight, and painstaking arrangement of the tables and food can make it. Potted plants, a few wild flowers or grasses, a spray of autumn leaves, lend a touch to the tables that the dining-room attendant who takes a genuine interest in her work is sure to call to her aid.

There are a few, but only a few, instances when it does not seem wise to ventilate a room directly by permitting the ingress of fresh air from outdoors. In such cases, do not make the mistake of opening a door into a cold hall or adjoining room and think that you are supplying pure air. First directly ventilate the room from which you are to draw your supply, making sure that the air in that is thoroughly renovated, and warmed, if need be, then open the door between the room you wish to ventilate and the one you have already ventilated, and your patient can thus get the benefit of the interchange of air between the two rooms.

Nurses have to combat all kinds of prejudice against pure air; some patients will put down a window as often as the nurse can put it up. It is not always easy to deal with these difficulties. Individual cases call for various ways of handling. Infinite



tact and patience, a painstaking explanation in some cases, persistence in others, and a gentle but firm reminder that the rules of the institution in this respect must be obeyed, will usually make the patient feel that he must conquer his prejudices against fresh air, or at least submit to the sanitary regulations of the hospital; and this is, of course, far better than to have him feel that the nurse insists on keeping the windows open to have her own way, or just to spite the patient.

Take advantage of opportunities to air the rooms of patients when they leave them for meals, to go out walking, and the like. Sewing rooms, dormitories, clothes rooms, bathrooms and water-closets should receive systematic attention in this all-important matter.

There are various means of artificial ventilation, either by heat currents, as fireplaces and basement furnaces (dependent on the fact that air, when heated, expands and becomes lighter, and so rises), or by forcibly drawing the air into rooms with fans, or by suction by a pumping apparatus. Rooms heated by furnaces have the disadvantage of all the moisture being withdrawn from the air. In such rooms dishes of water should be kept. Nurses need to familiarize themselves with whatever means of heating and ventilation are in use in the institutions or the homes where they are employed, whether it be stoves or furnaces, steam or hot water, direct or indirect radiation, and in each case should learn how to control and regulate them.

In the hospital departments, as has been said, the need for frequent and effectual ventilation is much greater than on the wards. Patients are congregated there day and night, they are sick in body as well as in mind, their exhalations are more foul than those of persons with sound bodies; evacuations are frequent, and, even with the utmost precaution, they contaminate the air. In such rooms, then, it is imperative that exits for foul air and entrances for fresh air be in continual operation, day and night. In addition to this, windows should be widely thrown up and pulled down frequently in the course of the forenoon and afternoon, and during the night, especially after evacuations of the bowels and bladder, and after dressings have been made. Soiled and infected linen and dressings should be promptly removed

from the hospital. Vomited matter, evacuations from the bowels and bladder, should be covered with a towel or a rubber cloth and promptly carried from the room, expectorated matter should be collected in sputum cups whenever possible, and when not, in a paper napkin which is to be disinfected and put in the water closet immediately if it cannot be promptly burned; in the case of patients who cannot be trained to use either cup or paper, eternal vigilance must be exercised, to wipe up the sputum immediately and dispose of the contaminated paper by immediate burning, or in the water closet.

Precautions should be taken to cover the patients especially well when thorough ventilation is in progress, by pulling the covers over the head if need be, using extra blankets, and placing screens for protection. But thorough ventilation there must be. It is of far more value than medicine. In many cases it is the most efficacious remedy we can employ. For continuous ventilation it is well to remember that several windows opened a little are more effective than one or two opened a good deal.

There still exists in the minds of many the erroneous notion that the air of a room can be purified by creating an odor to cover up the odor already there. Various fumigating powders, incense sticks, pastilles, and the like, are employed with this object in view. They may cover up an odor; they can never purify. They cannot remove the carbon dioxide from the air, nor supply the needed oxygen.

The temperature of the wards and rooms needs to be higher than that of the hospitals — 68° to 70° F. for sedentary persons, while 65° to 68° F. is usually ample for patients lying in bed continually; although anemic, feeble, and consumptive patients need a higher temperature (70° F.) than well-nourished bed patients, and fever patients need less than any others — 60° to 65° F. usually.

The halls and hospitals are provided with thermometers for registering the temperature of the room. These should be hung at central points in the room or ward, and not near a gas or electric light or a window. It is the duty of the charge nurse to watch the registering of the thermometer every hour, to record its registering as often as the rules of the institution require,

and to be guided by it in regulating the temperature of the ward, taking immediate steps to remedy the temperature that is too high or too low, by increasing or decreasing the supply of heat.

As we need to consider the maintaining of warmth in the sick room in winter, we also need to consider means for cooling it in summer. By keeping windows open as far as possible, above and below, all night, then closing or nearly closing them about 8 A.M. for several hours during the hottest part of the day, the heat can be somewhat diminished. Fresh air must then be secured indirectly from adjoining rooms, when the plan of admitting no out-of-door air is adopted. By judicious arrangement of shutters and dark shades, the heat can be appreciably lessened. When the heat is extreme, large blocks of ice placed in shallow tubs, sheets wrung out of hot water and hung before the open windows, spraying with Cologne water, and placing large branches of trees in jars of water in the room, are means to lessen the suffering.

In addition to ventilation and an equable temperature of the wards and hospitals, the importance of sunlight needs to be emphasized. Sunlight is a purifier. There are few conditions in which an abundance of sunlight in the room is not decidedly beneficial. In certain difficulties with the eyes, the light needs to be subdued, or the room even darkened, but in most cases the sun should be welcomed as a potent means of health and cheer. Care must be taken, though, to see that the rays do not fall across a patient's face, and that his bed is not so placed that he faces a glare of any kind. Nurses need to remember that the sunlight changes its position, and that a patient whose bed is comfortably placed at 3 P.M. may need later to be protected from the shifting afternoon light by a proper arrangement of shades and shutters. A nurse should be chagrined to have her attention called to helpless demented patients who lie winking, blinking, and sweltering in the afternoon because of her neglect to lower a shade, or change its position, or even the position of the bed, if the difficulty can be remedied in no other way. Sometimes the window shades blow out, letting bands of light come through the sides, and in order to get the benefit of the air the nurse lets the shades flop, even though the sunlight streams into the eyes

of some patient. Simply pulling the bed out of line for a while will obviate the difficulty in many instances.

Next to ventilation and the maintenance of a suitable temperature and an abundance of sunlight, we need to consider the means for cleanliness of the halls and various rooms, and the hospital departments. The nurse in charge should have the work arranged and apportioned in a systematic way, each of her helpers having her stated daily tasks. Carpeted rooms need to be swept with damp brooms, care being taken always to sweep with the broom near the floor and not to flirt the dust about; walls and ceilings require frequent washing; rugs need to be vigorously brushed and shaken out of doors, bedsteads carefully cleaned and inspected every week, mattresses and bedding are to be kept clean and in repair, the muslin coverings of screens immaculate; the tops of wardrobes, bureaus, stand and commode drawers should be kept free from food, refuse, and rubbish. Repairs of furniture call for prompt attention; creaking hinges are to be oiled; rattling windows made quiet; torn shades mended; worn curtains and rugs darned; windows and mirrors polished; in short, systematic attention must be given to all the details of hygienic housekeeping.

The thorough and systematic daily airing of the beds must never be neglected. In order to air a bed properly, each article needs to be removed separately, shaken and spread out on the backs of two chairs if possible, the mattress uncovered, the pillows beaten, and the bedding subjected to a thorough airing. With pains being taken in this particular, many of the patients can be trained to this task regularly and well. If they cannot be so trained, the nurse must make it a matter of her daily attention. It is desirable that a bed shall air at least two hours before being made up for the day. In dormitories where it is the custom not to make the beds up until night, the mattresses are left exposed, and the bedding arranged in various systematic and orderly ways, according to the customs in vogue in given departments. Whatever secures the most thorough ventilation is the most desirable.

In the hospital departments the duties are very different from those concerning the care of the halls, sitting rooms, and rooms



occupied by patients not requiring bed care. Here, as before stated, we have to deal with large rooms occupied by patients day and night, and the necessary ventilation, cleaning, and putting to rights has, as a rule, to be done while the patients are in bed in the rooms. Of course during the semiannual and annual housecleaning patients are usually temporarily transferred to adjoining wards, but during the daily and weekly cleaning, the matter is complicated by having to keep constantly in mind the comfort and welfare of your patients. The proper removal of dust, which is the source of so much disease, is one of the chief things to be considered; it must be removed so quietly and effectively that your patients are not inconvenienced by the process. To this end the tops of windows and door casings, the woodwork generally, picture frames, and all dust-collecting surfaces must be wiped daily with damp cloths, and the floors brushed with hair brooms, and then dusted with damp cloths wrapped around the brooms. No more water than absolutely necessary should be put on the floors, as water only tends to destroy the floor dressings and so render the floors a source of danger, because of their absorption of impurities.

When water is used to cleanse the floors, it should be frequently changed, and should contain whatever disinfectant for the purpose is in vogue in the institution. The use of disinfectants will vary in different institutions and in different parts of the same institution. Dust cloths need to be frequently wrung out of a weak solution of carbolic acid which should be changed often, and the cloths cleansed in hot soapsuds and a carbolic solution before being put away in the drying room. All mops and cleaning cloths should receive the same careful attention. If a floor dressing of turpentine and wax is used, it is applied with a flannel pad, and needs to be used every ten days or two weeks to keep the floors in good condition. Instead of this dressing, crude oil is often rubbed in the floors, and the excess rubbed off with the flannel polishers. Especial care must be exercised with oiled rags and cloths used for this purpose, because of the danger of fire from them if they are allowed to lie in a heap. They must be immediately rendered safe by washing, or promptly burned.



When the help of able-bodied patients is enlisted in the work of sweeping, dusting, and cleaning, it is of the utmost importance that such work be carefully supervised by the nurse in order to prevent negligence, the throwing of dust, the soaking of floors, the jerking of beds, and other injuries and annoyances to ill and helpless patients.

If the nurse in charge requires of her subordinates care and consideration in these matters, the patients will often find, in the orderly and systematic putting to rights of the ward, a source of daily interest instead of a disorderly, dust-choking scene of confusion, such as obtains where system and attention to details are wanting.

Beds must be frequently aired and sunned, mattresses brushed vigorously with a whisk broom at least once in two weeks, and bedsteads washed with a weak carbolic solution. On wards where the patients are unclean, this cleansing of the bedsteads needs to be much more frequent, on some even a matter of daily attention.

Especial vigilance concerning vermin is needed after admissions, and also immediately after the visits of persons whose appearance makes one suspect that they may be the carriers of these pests. This must, however, be done tactfully, so as not to give offense to the patients who have just been admitted or visited.

All soiled clothing, bedding, and dressings should be removed promptly from the hospitals and placed in the closed receptacles provided for them, until they can be put in the clothes chutes for collection by the laundrymen, or in the dust chutes for destruction by fire. Remove all pins from clothing, and all fecal matter, roll the very dirty articles in bundles by themselves, and make out duplicate lists of all articles sent to the laundry, retaining one for comparison on the return of the clothes.

Especial care must be given to all vessels and utensils used in the hospitals, lavatories, and bathrooms. These should never be put away until thoroughly cleansed, and the basins, hoppers, water-closets, and bath tubs require the most diligent attention to keep them clean and free from odors or contaminations. Your patients will often be careless about flushing the closets.

Their negligence must be promptly followed up by the nurse. Any failure of the closets to flush properly, or any defect in the drainage, should be reported at once to the engineer. Excretions should not be allowed to stand in the vessels at any time, day or night, when nurses are at hand to empty them. But in the rooms and dormitories, between the rounds of the night nurses, this is sometimes unavoidable. The nurse should, however, encourage patients to cover the vessels until such a time as she makes her next round.

Food or dishes which have contained food and medicines, as a rule, should not be allowed to remain in the rooms or hospital departments. Trays, cups, glasses, are to be immediately removed and cleansed after using. Withered flowers, stale water in flower jars, and plants that have ceased to be decorative, are to be promptly removed from the wards, rooms, and hospital departments.

The bedding should, of course, be changed as often as it is soiled, day or night, and pride taken to prevent the mattress and pillow tickings from becoming stained, the blankets and counterpanes from becoming soiled or torn, and the rubber sheets from being cracked, pinned through, folded, or injured in any way.

Soiled mattresses and blankets unfit for use should be sterilized and put away until a sufficient number have collected to be sent away to be cleaned.

Window ledges and fire escapes are to be carefully inspected, to the end that decaying fruit, food, excreta, and rubbish are not allowed to collect there, and especial pains should be exercised both day and night, that patients do not get an opportunity to throw these things, or articles of clothing, or anything from the windows. Hallways and stairways, mop closets, drying rooms, linen rooms — every nook and corner needs constant supervision.

Inspection day is a day set apart once a week when the physicians take especial pains to see that perfect order and cleanliness prevail. On other days in the week it is the duty of the supervisors to make this matter one of close attention. On regular inspection days the drawers of bureaus and commodes, the doors

to wardrobes, and closet doors are to be left open so that the interiors can be readily inspected. This is not for the benefit of the physicians. Aside from the object of keeping the wards up to the highest standard of hygiene, it has its value in disciplining the nurses and patients to regular and systematic attention to orderliness; it prevents the accumulation of rubbish, and it enables the nurses to discover purloined articles which certain patients are prone to hide away, but which cannot long go undiscovered if this weekly putting to rights is rigorously attended to.

## CHAPTER VII

### THE CARE OF BED PATIENTS

BED treatment is one of the most efficient means of building up the sick; notably those who are unsound of mind as well as of body.

In order to be truly efficacious, certain requirements concerning bed treatment must be met. The bed must be clean and comfortable. To be clean means that the bedstead, springs, mattress, mattress protector, sheets, blankets, coverlid, pillows, and pillow slips shall all be clean and well aired. To be comfortable means that a good article be purchased, the springs and mattress renovated as often as necessary, and the furnishings sufficient, clean, and arranged in an orderly manner.

For the sick the ideal bed is a single iron one, white enameled, and with double woven-wire springs, and a hair or high grade "felt" mattress. The bedstead should, of course, be on casters, and should, if possible, be so placed that the nurse can approach it from all sides. If a bed is found to be too easily moved, by reason of the casters, thus annoying the patient, the ones at the foot of the bed may be removed and still the bed be easily managed. Casters which do not move easily, or which squeak, need to be oiled and kept free from dust and other accumulations. Beds in hospitals require the most scrupulous care to prevent bed-bugs from getting any start in them. The frequent examination of bedstead, springs, and mattress, and the regular cleansing of them, are among the regular, never-to-be-neglected duties of the nurse. A weekly going over the bedsteads with a disinfectant and a careful insertion into all the joints and crevices of tooth-picks dipped in carbolic solution have been found effectual means of getting rid and keeping rid of these pests.

Most hospital beds are supplied with two pillows, one of hair

and one of feathers. The bed covering should be light but sufficiently warm, the sheets preferably of cotton, and either a very light-weight counterpane, or a white sheet used as a coverlid.

In selecting mattresses for your patients, take pains to select the best and most even mattresses for the ones who have to be most constantly in bed, and of course report for disuse all lumpy, uncomfortable mattresses or worn-out springs.

In many of the hospital departments it is necessary to protect the mattress by large rubber sheets covering the middle third, or even in some cases the entire length of it. These are expensive articles, and in addition to the painstaking care necessary to keep them hygienic by daily airing, and by cleansing as often as necessary, it is important to see that they are never folded or creased in any way, as this ruins them. They should be rolled when not in use. Pins should never be put in them. Stains not easily removed by water may often be removed by Labarraque's solution or by hydrogen peroxide. Sanitas or some other disinfectant is used on them daily.

Two ways of making the beds in reference to the use of the rubber sheet are commonly in vogue, some nurses claiming to get the better results with one, some with the other. The width of the mattress and the class of patients have to be taken into consideration; whichever method gives the best results should be employed.

The one that seems to me to give the best results is to cover the mattress first with the lower sheet, tucking it in as elsewhere described. Then place the large rubber sheet crosswise the bed in its middle third, fastening it securely by fitting it well around the mattress underneath, every part of it above and below the mattress being smoothly spread out. Over the rubber sheet place a folded sheet or draw sheet, with the hems placed at the bottom, if necessary pinning its four corners to the under side of the mattress. By this method, when the draw sheet is soiled, it can be removed, and the rubber sheet cleansed while remaining in place, and a fresh draw sheet applied, without the necessity for changing the lower sheet.

The upper sheet is put on the bed with its right side facing the



right side of the lower sheet, and with its wide hem at the top. This needs to be well tucked in at the foot, and enough of it left at the top to turn down over the tops of the blankets so as to protect them from becoming soiled, and also in order to keep the wool from coming in contact with the face. Double blankets should always be separated, as they are otherwise unwieldy. Blankets are allowed to come up high enough to admit of being tucked in snugly around the neck; care should be taken not to tuck the coverings in so tightly over the patient's toes as to cause discomfort. If sheets or blankets are too long, tuck the surplus in at the foot of the bed. Counterpanes should be removed at night, neatly folded, and so placed in orderly piles that they may be put back the next day on the same beds from which they were taken.

The beds in the hospitals should present as uniform an appearance as possible, the spreads put on evenly, the corners neatly arranged, the pillows similarly placed, and the bedsteads arranged in line. There are usually on every ward convalescent or chronic patients who can be trained to take pride in the neat and uniform appearance of the beds; such occupation should be encouraged when the patient's condition admits of it.

Stains on mattresses and blankets should be avoided as far as possible. When blood stains get on the ticking of mattress or pillow, one or two applications of a paste of starch or wheat flour, applied and allowed to dry, will usually remove them. Other stains may, as a rule, be removed with soap and water, or ammonia water. When the mattresses become badly discolored and stained, the stained parts should be cut out, and fresh ticking neatly set in.

In changing the bed linen the comfort of the patient should be the first consideration. Have everything in readiness, close at hand before beginning. Of course in many cases patients are able to sit in reclining chairs while this is done, which is desirable if the patient's condition warrants it, not only because the upright position and the change are a relief to the patient, but also because his removal from the bed admits of turning and shaking up the mattress and ventilating it in a way impossible if the bed must be changed with the patient on it. Very feeble patients

may be lifted on to another bed while their own is being changed, but in some cases it is necessary to change the bed with the patient remaining on it.

Those who have to stay habitually in bed should have a frequent change of mattress, the one after constant use being brushed, aired, and sunned for prolonged periods when not in use, while the other is substituted. If the patient is very ill and weak, matters are facilitated by having two nurses do the work of changing the bed; but if not, one deft and systematic nurse can accomplish it easily.

First, remove the pillows. The upper sheet and one blanket are left over the patient. Loosen the lower sheet and draw sheet at the top, bottom, and sides; from the side of the bed farthest from the patient the sheet is then folded lengthwise and as flatly as possible close up to the patient's back; fresh sheets folded lengthwise, alternately backward and forward for half their width, are placed close up to the folded soiled sheet, and the unfolded half of the fresh sheet is smoothly laid on the side of the bed from which the soiled one has been taken, and firmly tucked in at the side. The patient is then turned over on the clean sheet, the soiled sheets and the folded clean ones being drawn underneath, the fresh ones being smoothed out and tucked in at sides and both ends, and the soiled ones gathered in a heap on the floor to be quickly removed to the proper receptacles for them outside.

In cases where the patient cannot be turned on one side, it is necessary to lift him, while another draws the soiled, then fresh, sheets underneath him. In other cases, a bed may be drawn close up to the bed to be changed, and the patient gently rolled from one to the other, the bed then being drawn away and quickly fitted up with fresh sheets, then drawn back, and the patient again gently rolled or lifted on to the fresh bed. Or he may be lifted from one to the other in a strong under sheet. In moving a patient from the bed to a reclining chair, always place the chair with its back toward the bed.

In cases where it is needful to lift a patient from one bed to another, one person of ordinary strength who knows how to do it can easily manage with a patient of average weight, provided

he can coöperate a little. Place the head of the empty bed at the foot of the one occupied. Throw back the coverlids of both beds, and see that the patient's nightgown is well drawn down. Stand at the right of the patient, bend your knees, bring your right arm as far as possible under the patient, so that the upper part of his thighs rests upon it; then pass your left arm under the middle of his back to the other side; have him put his arms around your neck, and tell him to let his knees hang limp. Then lift him as you straighten your own knees and rise, bend yourself back so that the body of the patient lies upon your chest. Then carry him to the empty bed, taking great care to lower him gently to the middle of it, if possible having a second person standing at the opposite side of the empty bed, receiving part of the weight of the patient under your arms, so that he is gradually and gently lowered to the bed instead of being dropped there with uncomfortable suddenness.

With unconscious patients a second person needs to support the head; where a foot or a leg is injured, the injured member must be supported by another.

There are cases where it is necessary to change the bed linen from the top. In doing this, loosen the lower sheet at top and sides and push well down under the pillow. Have some one else stand at the opposite side of the bed and work down the soiled sheet, followed closely by the folded fresh one, raising in turn the shoulders, back, and hips with one hand, while working down the sheets with the other hand.

To change the upper sheet, free the clothes at the foot of the bed, spread the clean sheet over them, and a fresh blanket over that, tuck them in securely at the foot, and then draw out the soiled sheet and blanket from beneath, the patient not being uncovered at all during the process. If the sheet only is to be changed, the clean sheet may be folded across its width, tucked in at the bottom, and unrolled toward the top, the soiled sheet then being pulled down and removed at the foot.

It is a real boon to the sick to have pillows arranged comfortably. In changing pillows, the head of the patient is lifted and supported by the nurse's arm, the back is supported by the hand. The other hand turns the pillow, the lower pillow being

brought under the shoulders to support the back, the upper one to support the head. In lowering a patient's head, do it gently, not letting it drop back with a jerk. It is well if possible to have two sets of pillows, or at least three pillows, if four are not accessible. In this way the patient has the benefit of a fresh pillow frequently, while one is always being aired. If this is not convenient, as you remove the heated pillow take it away from the bed, shake it, change the slip, if necessary, pulling up the second pillow in its place, which in turn is taken and made fresh by a clean slip and by shaking.

When wishing to prop up a patient in bed in a half-reclining position, if you have none of the mechanical head rests or appliances for the purpose, a fairly comfortable one can be improvised by placing a straight-backed chair upside down in the bed, and arranging pillows on it, against which the patient can rest. Tuck a hair pillow low down against the small of the back, place another to support the upper part of the back and the shoulders, then a small cushion for the head at the top. In propping up with pillows alone, more pillows are needed. Crowd the lowest one well down against the small of the back, then put each additional pillow behind the last one, to prevent slipping. Patients inclined to slip down in bed need to be frequently raised back to the proper position, not by tugging at them from under the arms, but by sliding your arms under the hips, and having them aid you by pressing with hands and heels against the bed. Placing a hassock or a circular cushion at the foot of the bed to brace against will help in some cases, and in others placing a long firm roller pillow under the buttocks, the roller having tapes at each end which are tied securely at the head of the bed, will obviate this difficulty. Or roll a blanket or a light quilt in the required shape, covering with a pillow or bolster case to keep clean. There are other appliances which add greatly to the comfort of bed patients, such as knee pads, cotton and oakum rings for the heels, rubber air cushions, air and water beds, cradles for protecting the patient from the weight of the bedclothes, and the like. When cradles are used in the bed, they should always be placed under the blankets, the top sheet alone immediately covering the patient.

If no regular cradle can be procured, the nurse can improvise one which answers the purpose by joining two barrel hoops in the middle, and arranging them on the bed so as to remove the weight of the clothes from the body.

Helpless patients need to have their positions in bed altered from time to time, even when it is not a question of changing the beds or of adjusting the pillows. When necessary to do this, the nurse passes her arms well underneath the knees and shoulders of the patient. In other cases, very heavy patients may be moved and turned over on one side by means of the draw sheet.

All sheets and pillow slips should be well aired and thoroughly dry, and in cold weather warmed before placing on the bed. Bedding should be changed as often as soiled. By exercising constant supervision over untidy patients, to see that the rubber sheets and draw sheets are kept in place, and that the bed pan or the commode is frequently resorted to, the necessity of changing the bedding can be greatly reduced; and even in cases where the patients will not use commode or pan, the lower sheet need not in many cases be interfered with if the draw sheet and its waterproof sheet beneath be promptly changed before the lower sheet has time to become soiled.

When an abundance of bed linen is provided, it is not necessary to resort to the make-shift custom of using the crumpled upper sheet in place of the soiled lower one; but there are conditions where strict economy in the laundry work has to be practiced, and there are times when you will be short of the regular supply. At such times, shaking out, airing, and thoroughly heating the sheets that still have to be used, will do much to renovate them until you can obtain a fresh supply. Sometimes shaking and smoothing the upper sheet, and using it for a draw sheet will do nicely. One needs always to remember, however, that particles of worn-out skin, moisture, and emanations from the body are absorbed by the sheets, as well as by the patient's clothing, and that their frequent cleansing by washing is imperative, even when there are no stains or dust, or other visible signs of uncleanliness on them. When you cannot have fresh sheets as often as you would like, remember that keeping them pulled tight and straight on the bed, frequently pulling down the pa-



tient's nightgown, to free it from wrinkles, as well as bathing his back with alcohol, will do much to freshen the bed and refresh the patient. Add to this the practice of lifting the bedclothes from the edges and fanning them gently up and down, letting in the fresh air, and letting out the foul emanations from the patient's body, which practice will do a great deal to keep the bed hygienic and to render the patient comfortable.

Beds need to be brushed free of crumbs after every meal, the wrinkles smoothed out, and the upper clothing adjusted in an orderly way.

There is a tendency among insane bed patients to secrete things in bed — letters, spectacles, combs and brushes, tooth brushes, soap, and in the less tidy ones, food, rubbish, and even filth. The proper care of the beds requires that nothing be allowed in them except the bedding, the legitimate appliances as called for, and the patients. To help the patient in her very natural desire to have her personal belongings near her, and so guard against their use by others, it is perfectly admissible to allow her to have a little cotton bag which can be hung by its gathering string at the head of her bed, and in this her toilet articles, and such other belongings as she wishes, may be put. This can be kept presentable by laundering when necessary. The brushes and combs of patients less fastidious may be kept in the drawers provided for the purpose, and the tooth brushes, marked with the patients' names, in the racks arranged for them. Some patients provide their individual syringes, or at least the nozzles for them, also hot-water bags, and other appliances. When this is done, the nurse should be conscientious in keeping these articles set apart for the exclusive use of the ones to whom they belong. The individual wash cloths of patients, after being used, should be rinsed in hot water, and hung on the heads of the beds to air, not tucked under pillows nor put into drawers, nor into the bags heretofore mentioned, until they are thoroughly dried.

Where one has a choice, the sick bed should be placed so that it can be approached from all sides (but never in any case close up to the wall); it should be in a light, pleasant part of the room, but never facing a glare of light; and, if possible, so that an outlook of tree and sky may be obtained.

In hospital departments where there are many beds, the arrangement must be made advantageous, all things considered, to the greatest number, always remembering to give the most desirable places to those closely confined to their beds; the least exposed places to the aged and feeble; the least conspicuous to the untidy and unsightly ones, with due regard to the proximity of the lavatories for those who frequent them most, especially if difficulty in locomotion is experienced. Many patients prefer to help themselves in these matters, rather than to be waited on in bed; when able to do so, this should be encouraged. Bath robes and slippers should be at hand, and patients trained to use them in going to and from the water sections.

Convalescent patients and some others are able to be up and dressed throughout the day, but for one reason and another need to sleep in the hospitals. Such patients, when able, should be trained to air their beds on rising from them, taking off each article separately, shaking it, and exposing each to as free access of air as possible, leaving the bedding exposed till after breakfast, when the beds are to be made up for the day.

Convalescents and certain able-bodied chronic patients are often of distinct service in helping to care for helpless patients. Great care, however, needs to be exercised in supervising their work, to see that it is done well. Some well-meaning ones, willing, but lacking in judgment, will, unless watched, jerk the beds about, brush or lean against them in a way to jar or push them, sit or loll on them, when occupied by others, put trays on them instead of on the bed tables or stands provided, or, if they be allowed to feed others, may feed too rapidly, or in other ways prove inefficient. Press such patients as are permitted to work into your service when they can be trained to render efficient service (you will often find them more deft and tractable than some of your assistants), but always remember, however trusty you think them, to keep a watchful eye upon their work; and also remember that a little extra time spent in training them to do things properly will be more than made up in the long run.

**The Toilet of the Bed Patient.** — When the hospital nurse first comes on duty in the morning, after receiving the verbal and written reports of anything unusual in the night (more par-

ticularly concerning all cases especially sick), the first thing is to wash the faces and hands and comb the hair of the patients not able or not to be depended upon to do these things for themselves. Each nurse in a given division has her regular patients to look after, assigned her by the nurse in charge; she should have her toilet basket with the necessary articles ready, with everything to be used at hand before beginning each toilet. The details of bathing a patient are considered in another chapter. In this first toilet of the patient all the little niceties cannot be attended to, the main thing now being to render the patient presentable before receiving her tray. The full toilet of a patient takes more time, and at this busy hour of serving breakfast, is out of place; besides, most patients are too weak in the morning to be fussed over very much till after breakfast.

For the hasty first toilet, then, have the water, soap, towels, wash cloth, brush and comb all ready before beginning on a given case. Try to find something cheerful to say while quickly but gently performing this morning service; dry the skin carefully, and patiently and gently disentangle the hair. Long and heavy hair should be braided in two braids, well brought over to the sides of the head. If it is very much entangled, it must be separated into small portions and gently worked with until the snarls are removed. Do not tire your patient, if she is weak, by attempting to get the snarls all out at one time. Daily attention to the hair will, as a rule, prevent such matting as is here mentioned, but patients are often admitted with the hair in such a state, and time and patience are required to get it in a proper condition. In combing or brushing the hair, after brushing it gently away from the patient's face, so that no stray hairs fall over the face, grasp the long hair in the left hand, begin at the ends and work gradually upward, keeping the head steady and holding the hair so that, even when it is snarled badly, your efforts at disentangling will not hurt or jerk the patient. This can be done if you will go slowly, taking the hair in sections. Dress the hair before changing the bed linen, and take pains at all times to keep the bed and clothing of the patient free from loose hairs. The beards of male patients should be neatly brushed, and frequently washed and rinsed to keep them in a proper condition.

Patients who are able should be trained, if not accustomed to do so, to brush their teeth at least once a day. The weak and helpless should have their mouths attended to carefully at the bedside, the mouth cup with listerine or some cleansing mouth wash being brought to them with the basin to receive the rinsings; they should then brush their teeth and tongue or have them brushed; if this attention to the care of the mouth be given not only in the morning but after dinner and again at night before retiring, and the hands and face also bathed at those times, the increased comfort to the patient will repay the nurse for the extra trouble that it entails. The lips and mouths of fever patients and some others require frequent cleansing and moistening throughout the day to remove the rapid accumulation of sordes.

I realize that in our large hospital wards and with a large number of irrational and often very troublesome patients, some of these niceties of the toilet, especially in certain cases, seem rather too much to undertake. One cannot be dogmatic, and say that it shall be done in all the departments and with all patients; but even the most obstreperous cases should be patiently and persistently worked with till they will either brush their teeth once a day, at least, or let you do it for them.

Patients in bed, as a rule, need only an undervest and a nightgown or nightshirt on. The weight of the undervest should, of course, vary with the varying weather. This, as well as the nightgown, should be changed frequently, and, when practicable, one gown and shirt kept for day and another set for nightly use. In summer weather it is better in most cases to dispense with the undervest. There are a few aged and feeble patients who in severe weather, because of poor circulation, will need stockings and even underdrawers on in bed, but as a rule most patients can dispense with this extra clothing and be the better for it, if due attention be given to the temperature of the ward, to sufficient bed coverings, and to the use of hot-water bags.

Patients who are able to sit up in bed, or who wish to have their arms out a good deal, are made more comfortable if provided with bed jackets, kimono sacks, shoulder shawls, Nightingale wraps, and the like. The friends are often eager to furnish



these conveniences if you will but remind them of the need. Blanket wrappers, bath robes, and kimonos, with bedroom or bath slippers, are comforts which can frequently be procured for the asking. These should be kept near at hand and used exclusively for the patient for whom they are provided. The blanket bath robes and slippers, supplied by the institution for patients not provided with these conveniences, should be more systematically used than they are in some departments. This can be done if the nurses will work together to encourage patients to use these things instead of letting them jump out of bed and run to the section barefooted and in their night clothes. When patients sit in a reclining chair, their feet and legs should be covered with gray blankets kept for the purpose, or a lighter covering in mild weather.

Patients accustomed to soil the bed should be given short nightgowns, but a nurse who exercises systematic vigilance in such cases can usually break up the habit of uncleanness, and should be ashamed to have habitually unclean patients in her department, unless they are afflicted with a fistula, or with some other condition of rectum or bladder in which control of these parts cannot be acquired. By direct and regular attention to uncleanly patients, there are comparatively few cases where the habit cannot be broken up, or at least forestalled by timely attention in placing them on the commode.

Before changing the clothing of bed patients, have the clean, well-aired clothes at hand. Loosen the nightshirt or gown at neck and wrists, bring it and the undervest well up under the shoulders on one side of the patient; take out one arm from the soiled garments and immediately put on the corresponding clean sleeves, slipping both sets of garments over the head, thus slipping the soiled ones off and the fresh ones on. Go to the other side of the bed, remove the soiled clothing, and put on the other sleeves of the clean clothing, pull all down smoothly back and front. Bed garments are much more easily put on and removed if they are opened all the way down, but it is only occasionally that your patients are provided with such, so that your efforts have to be directed toward accomplishing the changes with as little exertion and as great a degree of comfort as possible.



In paralytics, or patients in which one side is injured, take the clothing off the sound side first, and put it on the injured side first, as this saves unnecessary movement and pain. Where the arm is fractured, the sleeve should be ripped open from the wrist to the neck, and tapes sewed on at intervals, to keep the sleeve in place.

Some bed patients need to be carefully supervised to prevent and to break up certain bad habits, not only the ones who are inclined to urinate or defecate in the bed, but also others who, unless watched, are given to using the sheets and pillow slips for handkerchiefs and sputum cups; some slyly remove the sheets and slips and lie on the ticking; others get between the blankets; others hide their heads under the clothes, thus breathing over and over the air contaminated by their own exhalations; others, because of lack of local cleanliness, together with too much lying in bed when such rest is not needed for recuperation, develop the habit of self-abuse; and others expend their restlessness and surplus energy in tumbling or tearing or unravelling the bedding.

These various manifestations need to be studied individually, the causes that give rise to them ascertained, and removed as far as possible. Idle minds and idle hands are frequent causes for these tendencies, and a resourceful nurse will not be long in supplying occupation and interests to bed patients whose condition admits of their engaging in them.

Bed pans and urinals should be scrupulously clean, they should be thoroughly dry and warm before use, and care should be taken, especially if there is any tendency to bed sores, to avoid rubbing or dragging the pan against the sacral region during its placing or its withdrawal. Request the patient, if she will coöperate with you, to raise her hips a little, put your hand under her sacrum and slip under the pan. In this way the pan comes in contact with your hand instead of the patient's back. In removing it, raise her hips slightly with your hand and slip out the pan. Very heavy and helpless patients may need to be lifted by two persons to avoid injury to the skin from rubbing or dragging. Patients afflicted with involuntary evacuations are made more comfortable, and mattress and bed

linen saved, by the use of a rubber protective pad which, when inflated and covered with gauze, is placed under the hips. By means of this the bed can be kept dry without frequent moving of the patient.

In conclusion, it is necessary to consider one of the most important things concerning the care of bed patients — the *prevention of bed sores*.

The first means to this end is the keeping of the patient clean and thoroughly dry, day and night, and the bed and body linen free from crumbs and wrinkles. Too much emphasis cannot be placed upon these measures. Keeping the patient well nourished is another potent means of prevention, as it is the feeble and emaciated, and those of reduced vitality, as a rule, who are prone to the formation of bed sores. Still, certain obese persons require painstaking care in this particular. Cases in which there is some trophic disorder, where the nerve supply is injured, may develop bed sores even with the most watchful nursing, but be careful how you excuse yourself, even on these grounds. I have seen advanced cases of general paresis remain free from bed sores to the very end, though emaciation was extreme, but such results were only reached by the most diligent and intelligent supervision on the part of both the day and the night nurses. An indolent and negligent night attendant can, of course, undo a great deal that has already been done by the day nurse.

The prominent parts of the body where continued pressure comes, unless the position is frequently changed, and the parts subjected to friction, are the places where bed sores are likely to form — the sacral region, the hips, shoulders, elbows, inner surface of knees, the heels, ankles, and ears are the usual seats. When the patient's condition admits of it, taking him out of bed even for a few minutes daily, and propping him up in the sitting posture, will temporarily relieve the parts upon which the weight continually falls. Prevention is like the proverbial stitch in time here; it is often exceedingly difficult to heal bed sores when once they are formed, but comparatively easy to guard against their formation.

Patients may sometimes speak of a prickling in the parts, or

other sensations of discomfort, but as a rule the danger signal, the reddened spot, is the first intimation you have of trouble brewing. It is the nurse's duty immediately to report to the physicians any suspicious redness of these susceptible parts. This rule is too often disregarded, and the first announcement made to the physician is that a bed sore has developed in a certain patient, the implication being that it just appeared. Now a nurse should be ashamed to make such a statement; bed sores are not like mushrooms that spring up in a single night. The nurse ought to know that it proves that she has either deliberately concealed its progressive stages, or that she has been lacking in the necessary daily care and scrutiny, and so has actually discovered it thus late herself, because of her own carelessness.

Prevention, then, consists first in breaking up uncleanly habits if possible; secondly, in cleansing and drying the patient just as often, day and night, as he is soiled, however often that may be; thirdly, in keeping his skin free from irritation by crumbs and wrinkles; and fourthly, in relieving the dependent and adjacent parts from pressure by frequent changes of position. Here is where cotton pads, cotton and rubber rings, cushions, heel pads, ear protectors, and, in serious cases, water and air beds, come into play.

Every sickness that bids fair to be a long one demands attention in this respect, before any warning signs appear. The skin over these susceptible parts should be hardened by bathing several times daily in dilute alcohol, or equal parts of alcohol and camphor, brandy, salted whisky, cologne, vinegar, or lemon juice, and the skin kept nourished by inunctions of cocoa butter. The parts subjected most frequently to moisture, after being thoroughly dried, should be well dusted with toilet powder, cornstarch, boracic acid, lycopodium powder, bismuth, or oxide of zinc.

If redness has actually appeared, the physician may order the skin painted with nitrate of silver, or if abrasions have already occurred, it may be protected by painting over with white of egg, with a coating of collodion, with a thin dressing of absorbent cotton held in place by collodion, or it may be painted

with picric acid, dressed with aristol, or any other application that the physician may direct, sprinkled on absorbent cotton and held in place by collodion, or by adhesive straps. These latter, however, are very unsatisfactory, as they not only easily become uncleanly, but also irritate the surrounding skin, besides being painful and difficult to remove. Castor oil and bismuth are sometimes used.

When the bed sore has actually formed, its treatment is outlined by the physician. Various measures are adopted, depending upon the extent, severity, location of the sores, and the condition of the patient, as well as upon the views of the different physicians, and the customs of the various institutions in which the patients are treated.

Whatever local measures are adopted, use them according to directions, but never forget that the frequent shifting of the patient's position, the removal of pressure from the dependent parts, and the prevention of friction are absolutely essential to improvement. Patients are often too weak to stay on their sides when placed there; pillows and pads well tucked in to support them, and soft pads of cotton hollowed out in the center and loosely held in place by gauze bandages at knees and ankles, may help reduce pressure, and thus promote healing.

## CHAPTER VIII

### BATHING AND HYDROTHERAPY

THE uses of baths are many and varied. In health we bathe to refresh ourselves, to keep clean (and, when necessary, to get clean), and to promote the free action of the skin. In disease we use baths for the above purposes and for therapeutic purposes as well — in other words, as remedial agents. Among the latter uses may be mentioned the reduction of fever and of inflammation, the inducing of free perspiration, and the modification of the circulation of the blood.

Patients in bed should have their faces and hands washed and hair combed before breakfast, and again before settling down for the night. They should also have a daily sponge bath, unless other baths are ordered. Necessary as this is in health, it is particularly so in disease. A bath should not be given within two hours of a full meal.

In bathing a bed patient, place her between bath blankets so as not to dampen the bed. The room should be warm and everything in readiness before the bath is begun. Have the clean clothing and bed linen, the wash cloth, soap, towels, wash basin, pitchers of hot and cold water, and the slop jar close at hand. Use a flannel wash cloth by preference, and be generous with your towels, discarding any that become damp. Have a care to change the water frequently, keeping it warm and clean throughout the bath. It is important that the patient shall not be chilled or fatigued by the bath.

When all is in readiness, remove the patient's clothing, letting her lie between the blankets, and of course bathe her under cover, or at the most expose only a part at a time. A few drops of ammonia, or a little borax, may be added to the bath water after washing the face, if the body is much soiled, or



if the odor of perspiration is strong. Alcohol, benzoin, and mildly scented toilet waters are refreshing when added to the bath water, and, as a rule, are not objectionable.

Pay especial attention to getting the corners of the eyes and the ears clean, clear the nostrils of patients unable to do this for themselves, and brush their teeth, or see that they do it. Give careful attention to the paring and cleaning of the finger and toe nails, which should be regularly pared at least once a week.

Bathe the face, ears, and neck first, drying each part thoroughly as soon as it is bathed. Have an abundance of water, use soap generously, especially in the axillæ and on the genitals, rinsing carefully, and drying thoroughly. Especial attention should be given to cleansing the umbilicus, to the folds under the breasts and abdomen of fleshy persons, to careful cleansing of vulva and anus, and also to the genitals in male patients, and to washing and drying carefully between the toes; also the palms and between the fingers of patients having contractures and habitually closed hands, dusting these parts with toilet powder after thoroughly drying them.

After the face, neck, and arms, bathe the chest and abdomen, drying each part as you go along, then the legs and back, lastly the genitals. Patients who can be trusted to bathe the genitals themselves, may be allowed to do so, but be sure that they can be trusted to do it thoroughly. Comparatively few women, even among the sane, realize the importance of careful attention to this part of their toilet, and need to be taught that these parts require daily attention even more than do the face and hands. Take especial pains to cleanse the clitoris, and watch your masturbation cases to see that no irritation from uncleanness is giving rise to this habit. Patients who are menstruating need to have the external genitals bathed with soap and warm water twice daily. Tell them that with thorough drying there is no possibility of their taking cold, if you find them objecting to this hygienic care.

In *bathing feeble patients* with sluggish circulations, especially in cold weather, it is a very good plan to have at hand plenty of hot towels to dry them with, rubbing the limbs vigorously and

toward the heart. Give a glass of hot milk immediately after the bath, and place a hot-water bag at the feet if they are cold.

If a feeble patient is ordered a tub bath, wrap her in a sheet, lowering her in it gently into the water; on removing her, roll the body in a dry, warm sheet and blanket, letting her lie thus instead of subjecting her to the immediate process of drying. After perhaps ten minutes, dry quickly and gently with a towel.

Many of your patients are strong enough to go to the bathrooms for sprays, showers, or tub baths. In these journeys to and fro, see that the patient's feet are protected by slippers, the body by a sheet, kimono, blanket, or bath robe, according to the weather, and the conveniences provided; see that clean clothing is near at hand, warmed and ready as soon as the patient is thoroughly dried. Do not wait till she is ready for it before getting it ready.

In tub baths for cleanliness, the same attention to details noted in the sponge bath should be observed. In the tub, always take pains to keep weak patients from slipping, or getting startled in any way, resistive ones from getting injured, and all patients from getting burned either by the skin touching the hot-water faucet, or by a stream of hot water touching any part. All depressed patients must be the object of special and continual surveillance, lest even attempts at suicide occur.

Take especial pains in washing the hair not to let soapy water trickle into the eyes. Do not leave a feeble or demented patient alone in the tub for an instant, nor an epileptic, a general paretic, nor one whom you have reason to suspect of being suicidal. Do not leave any insane patient alone in the bathroom unless you have had specific instructions from the physicians so to do. Do not leave the bathrooms unlocked, and thus accessible to insane patients, unless a trusty attendant is continually at hand.

Help weak and aged patients in and out of the tub, whether they think they are able to help themselves or not, and aid them in drying their bodies and in dressing, taking pains to see if they react properly after the dressing is completed.

In all administrations of baths to the insane, it is of the utmost importance that you so tactfully and skillfully deal with

your charges that they look forward to their baths with pleasure. As has been emphasized in another chapter, the manner of giving the bath, especially the first bath, has a great deal to do with the patient's attitude to this important part of the care and treatment. Never count time lost that is spent in patiently and tactfully attempting to conciliate a patient who shows a tendency to fear or resistance in regard to the bath.

*Baths for remedial purposes* are very different from those for cleansing purposes, and in order to be intelligently applied, the nurse needs to know what effects may be expected from the various measures adopted; what effect is hoped for in a given case; what are the signs that indicate danger; what to do in such conditions; and how to administer the various hydriatric measures with the best results.

Baths are general and local, continuous, graduated, medicated, of water in varying temperatures, of hot air, and of vapor; then there are electric-light baths, sun baths, and mud baths — all of which are prescribed according to the object to be attained.

The generally accepted *temperatures for baths* are as follows:—

Cold	.	.	.	.	.	33° to 65° F.
Cool	.	.	.	.	.	65° to 75° F.
Temperate	.	.	.	.	.	75° to 85° F.
Tepid	.	.	.	.	.	85° to 92° F.
Warm	.	.	.	.	.	92° to 98° F.
Hot	.	.	.	.	.	98° to 112° F.

Bath thermometers should be conscientiously used, and the bath kept within the limits prescribed. In testing the temperature of the bath water, first mix the water well with the arm or with a long wooden stick, then dip the thermometer into it, wait till the mercury ceases to rise, then read the temperature while the bulb is still under water. If the bath thermometers are fitted with cork so as to float upright in the water, so much the better.

The *effects of cold baths* are briefly as follows: first, chilliness and depression, then quickened pulse, but lowering of temperature as the blood is driven from the surface to the internal

organs. Reaction, if it takes place as it should, soon shows in increased circulation, followed by a warm glow and by a feeling of exhilaration. The entire process should last about five minutes. A protracted cold bath results in a return of the chilliness and depression and a weakened pulse; this result should not be allowed to take place. As a rule, enfeebled persons cannot react well to cold baths, at least to cold plunges, and have to begin with a plunge in tepid water, gradually lowering the temperature by adding cold water or ice. Many who cannot stand these measures derive most excellent tonic effects from cold sponging, especially if they take the precaution to stand with their feet in warm water during the sponging.

**Cool or Tepid Sponging.** — This bath is given in feverish conditions for the purpose of reducing the temperature and soothing the restlessness attendant upon fever.

Water alone, tepid or cold, as ordered, may be used, or alcohol may be plentifully used in the water, or alcohol alone may be used. (In some cases hot sponging, with vinegar added to the water, is ordered, in which case the mode of procedure is about the same as for cold sponging.) The sponging is in the main done in much the same way that the sponge bath for cleanliness is carried out. Everything must be in readiness at the start — pillow protector, bath blankets, towels, water, ice, alcohol, two basins, two sponges, and the drinking water.

Omit the scrubbing and other details necessary when the toilet of the patient is being made. Place the nude patient on the bed between the bath blankets. Put an ice bag or a cold compress on the head and a hot-water bag to the feet, and give cold water to drink frequently during the bath. Sponge the face and neck with several light, slow strokes, changing the sponge every third or fourth stroke, and sponging each part three or four strokes before going to the next. Sponge arms, chest, and abdomen slowly and lightly from above downward without friction. If the fever is very high, after sponging face, arms, chest, and abdomen, before going to the legs, wring a towel out of cold water and spread it on the chest and abdomen, tucking it well in at the sides, so that it will stay in place when you turn the patient on the side to sponge the back. Sponge

the thighs, legs, and feet somewhat less than chest, abdomen, and back. Support the patient with one hand while sponging the back with the other. In sponging for the reduction of temperature, exposing the parts to the air assists the process, and wrapping the patient up in a blanket, instead of drying with a towel, is not only less fatiguing, but also aids in lowering the temperature. This bath should take about twenty minutes. The rectal temperature should then be taken, and instructions followed as to how often the bath should be repeated. If it is to be repeated often, it is better to leave the patient wrapped loosely in the blanket between times, but if not, place the patient on the back and put on a long gown opened all the way down the back, and simply tucked close to the body at the sides, but not buttoned, thus avoiding unnecessary moving of the patient.

In sponge baths for the purpose of reducing temperature, extra pains needs to be taken not to fatigue the patient; do not let him help; support each part yourself, gently turn him when necessary, but do this as little as possible. Although the procedure should be done rapidly and deftly, it should have no appearance of haste or confusion. The temperature of the water can be kept at 65° F. by adding lumps of ice when necessary.

In *sponging for the night sweats of phthisis*, the chief variation in the technique is to sponge quickly instead of slowly, and dress the patient in a fresh, well-aired nightgown, a complete change of bed linen having been effected before the blankets were put in place.

**Ablution.** — This measure is useful in mild febrile conditions, and is also valuable as a tonic and refreshing agent in neurasthenic cases, as well as in anemia, chlorosis, and phthisis. Its chief value consists in the shock it gives to the peripheral nerves and blood vessels, followed by stimulation and a feeling of invigoration. The breathing and the circulation are quickened, and the beneficial effects are seen later in the entire system.

Have several vessels with water at varying temperature within reach. Put the rubber sheet and blanket on one side of the mattress. Spread over these a linnen sheet, fastening it under them on the edge toward the center of the bed, letting one half of the sheet reach over the edge of the bed. Place the nude



patient on the sheet. Bathe the face (65 to 50° F.), beginning with the higher temperature, and reduce two degrees at each application. Dash cold water from the hollow of the hand, or from a crumpled gauze wash cloth, upon the chest, then upon the arms as far as the elbows, the back, abdomen, thighs, gently rubbing each part after applying the water, frequently dipping the cloth and squeezing the water over the parts. Dry the body by friction with coarse towels, or, if ordered, wrap in a dry sheet in readiness on the other side of the bed, and allow the patient to dry in that way. Avoid chilling.

**General Ablution.** — The patient stands in twelve inches of water (95° to 100° F.). Wash the body downward rapidly with the hands, having water (50° to 80° F.) poured over the patient from a pitcher, followed by gentle friction. Lower the temperature each day till he becomes accustomed to the lowest. Explain to the patient the importance of the shock of cold water to increase the respiration and circulation and to tone up the system. Dry by vigorous rubbing.

**The Half Bath.** — The half bath is more intense in its effects than the ablution. Its chief use is in chronic conditions, and to restore tone after wet packs and other measures have produced dilatation of the cutaneous vessels. The temperature then should be from 90° to 85° F. Its duration should be from six to ten minutes. The greatest value of this bath lies in the effect produced by the mechanical application of water, in successive shocks, and by the friction, which is more easily performed since only the pelvis and limbs are under water.

Put a cold turban on the head. Place the patient in the bath tub containing water enough to cover the hips and legs (85° to 70° F., or after a wet pack 85° to 90° F.). Bathe the face, then rub the back with the left hand while dashing water from a small, long-handled dipper over the shoulders; the patient meanwhile, if able, rubs his chest and abdomen with both hands. Add cold water from the other vessels till the patient shivers. Remove the patient if the teeth chatter. Wrap him in a coarse, warm sheet and dry rapidly with it. Dry feeble patients in bed on a blanket and warm sheet. If the patient is too weak to sit up, have him lie in the bath tub and rub him under water.

**Affusion.** — Affusion is still more energetic treatment than the ablution. The entire process should be of very short duration, and extreme tact should be used with nervous patients to let them understand the beneficial effects of what seem like heroic measures to them. On no account is the patient to be allowed to feel that this bath or any other hydropathic measure is given in any sense as discipline or punishment, but only as a means of treatment. It is better that a physician be present the first time that affusion is prescribed for a given case, and also that one be present in every case where the patient is in a critical condition.

Affusions are efficacious by reason of the sudden force of the volume of water striking a large surface of the body at once, producing a mechanical as well as a thermic influence, benefiting the entire economy through the quickened respiration and circulation, the improved nutrition, and the invigorated nervous system. Unconscious and delirious patients, cases in which there is cyanosis and threatening heart failure, cases where the bronchi are loaded with mucus, are speedily helped by properly administered affusions. It often requires courage to adopt such measures, but a few trials will convince one of the efficacy of affusions in such conditions.

The patient sits or stands in the empty tub or lies on a rubber cot. Pour upon the head, shoulders, and body a stream of water (65° to 50° F.) from a pail or a pitcher held at a short distance above him, the distance gradually increasing. Do all this rapidly. Dry the patient with a warm sheet wrapped around him.

Place feeble and delirious patients in a semi-recumbent position in the water at 100° F. Douche the upper part of the body with water from 50° to 65° F. Dry rapidly, as above.

**The Sheet Bath.** — The sheet bath is used in acute conditions to reduce the temperature in cases where the patient's condition does not admit of the full bath, and in chronic conditions for its invigorating effects upon the nervous system. The first effect of the cold sheet is to shock the patient; he will gasp and shiver, but if he has a high temperature, his own heat will cause this shivering to disappear, and in chronic conditions the manipulations of the nurse will overcome the unpleasant

symptoms. Chattering of the teeth shows that the measures are proving too extreme for a given case.

Protect the bed or cot with a rubber sheet, then spread over it a blanket. Have in readiness several sheets, preferably linen, a basin, a tub of water of the required temperature, a cup, and a sponge.

Wrap the nude patient in a blanket, bathe face and head in cold water, fasten an iced turban on the head. Another attendant drops one sheet lengthwise into the tub of water (50° to 80° F. as ordered), holding it so that he can easily remove it. Wring out the sheet. Spread it on the bed rapidly so as to maintain the required temperature. Quickly lay the nude patient on the wet sheet with the arms above the head. Bring the upper left border of the sheet close under the left axilla, and lay across the front of the chest. Tuck the lower portion between the lower extremities. Lower the arms to the sides. Carry the right portion of the sheet across the body above and below, covering the shoulders, arms, and lower extremities. Sweep with outstretched hands firmly over the entire body till it warms up. As soon as any part is warmed, pour water (50° to 60° F.) over it from the cup, and resume the rubbing. Alternate these frictions and pourings till the whole body feels cool and the patient shivers, but stop short of chattering of the teeth. Retain the wet sheet. Cover the patient with blanket and rubber sheet for one half hour. Do not disturb him if he sleeps. Dry with friction and a warm sheet or towels.

**The Drip Sheet.** — The drip sheet differs but little from the sheet bath except that it is more energetic and more suitable for chronic and able-bodied cases than is the sheet bath. It is given in the standing position, which admits of vigorous friction. This is the thing to be desired in this bath, rather than the reduction of temperature. It has been found especially efficacious in chlorosis and anemia; in the psychoneuroses, such as neurasthenia, hysteria, psychasthenia; in melancholia, and in pulmonary and bronchial troubles.

When tonic effects are sought, from two to five minutes are sufficient, but when the aim is to lower the temperature, fifteen to twenty minutes are needed.

The able-bodied patient stands in a foot or bath tub in twelve inches of water (100° F.). Dip a sheet in water at 75°, daily reduced till it can be tolerated at 60° F. Raise the right arm, place the dripping sheet under the right arm, lower the arm, holding it close to the side. The patient then turns around in the tub, thus enveloping himself in the sheet. Tuck the upper border around the neck and wrap the lower border around the legs. Make rapid passes over the sheet up and down the back, sides, and lower extremities, with outstretched hands, occasionally slapping the surface. Pour a basin of water, ten to fifteen degrees lower than that the sheet was dipped in, over the head and shoulders two or three times, at short intervals, alternating with friction for five or ten minutes. Remove the sheet, have the patient step out of the tub on to a blanket, and quickly dry him with a warm sheet.

**The Cold Rub.** — The cold rub is best given in the morning on rising. It is particularly useful in anemia and phthisis, and for insomnia. The length of time for its application varies with the case, and is usually prescribed by the physician.

Wring a coarse linen sheet out of water at 60° to 75° F., and wrap the patient as in the drip sheet. Make vigorous friction with rapid passes and energetic and frequent slapping. Drop the wet sheet, dry with a warm sheet and towels. Dress the patient rapidly, then have him take a glass of hot milk, and, as a rule, walk briskly in the air for twenty minutes.

**The Wet Pack (Cold Pack).** — The wet pack is another means of reducing temperature. It is used for this purpose in fever cases, especially where there is delirium, also in hysteria, and in other functional nervous conditions, to allay irritation and to promote sleep. Other conditions may also call for this measure, such as diabetes, rheumatism, gout, anemia, chlorosis, and digestive disorders; in short, in any condition where we wish to aid tissue changes and improve the circulation.

One needs to be cautious in its use with the aged and feeble, especially with those having weak hearts or hardened arteries. The effect of the wet pack is stimulating, it causes vasomotor contraction, and drives the surface blood to the brain and other organs; consequently an ice bag to the head is necessary and a

hot-water bag to the feet. The first effect noted is a shock lasting from five to twenty minutes, according to the reactive powers of the patient; sometimes the patient gasps and shivers and begs to be removed, but as the cutaneous blood vessels begin to dilate, a comfortable warmth steals over the body, often inducing a refreshing sleep. If sleep is the object to be attained, leave the patient in the pack until he awakens. In very high temperatures the sheet steams, and if the pack be continued too long, the cold pack becomes essentially a hot pack. This is desirable in some cases, where the elimination of toxins is to be attained. The continuation of a pack for three hours may, under such circumstances, be prescribed — a matter, however, which is for the physician to decide. But when reduction of temperature is the object sought, the pack needs to be renewed as often as the body warms the sheet. In such cases, beginning the first pack with a temperature of 60° to 70° F., as soon as the pack becomes warm, a new one is applied two degrees higher, and again another and another, each two degrees higher, till about five packs have been applied, each one of about ten minutes' duration. The last pack, which cools but does not chill the patient, should continue about fifteen minutes, followed by a rapid ablution of 50° to 60° F. before the patient is dressed.

In giving a wet pack, remember that its success depends upon completely excluding the air from beneath the blanket which surrounds the wet sheet.

Have the patient first empty the bladder. The bed should be narrow and accessible on all sides. Cover the mattress and the pillow with a long rubber sheet. Spread the bath blanket upon the mattress so that it extends two feet beyond the patient's feet, the left third hanging over the left edge of the bed. Spread a large, preferably a linen, sheet well wrung out of water (60° to 70° F.) on the blanket. Wrap the patient's head in a cold, wet turban before placing him nude upon the bed, well to the right side. Put his arms above his head. Draw the right third of the sheet across the body from right to left. Tuck the upper part in along the left side of the trunk, place the lower part between the lower extremities, lower the arms to the sides, bring the left overhanging part of the sheet over from left to right,



enveloping the arms and the entire body, and tuck its border along the right side. Draw the blanket from the left and tuck under the right side of the body, and draw the right border of the blanket over to the left in the same way, securing firmly under the body. Draw the upper corner around the neck and secure beneath. Tuck the lower border firmly around and over the feet. Cover the patient with several blankets. Continue the pack from one half to one hour, as directed. Follow it with a half bath, sheet bath, cold ablution (70° to 80° F.), or cold spray, as ordered. This is necessary in order to restore the tone to the relaxed cutaneous vessels.

**The Full Bath.** — A Full Bath means a complete submersion of the body in water, the water touching the chin, the head only being uncovered. There are three kinds: —

The Cold Full Bath,  
The Warm Full Bath, and  
The Hammock or Continuous Bath.

In order to apply these properly, a portable bath tub is desirable, though not always obtainable.

The *Cold Full Bath* is used more particularly in typhoid fever and other infectious fevers, and is what is known as the *Brand Method*. It is dreaded by the laity and by many physicians because of its heroic character, but if properly applied, its beneficial effects soon convince the timid of its efficacy. Chafing of the body during the bath is the important thing to insure its success. The patient almost always gasps and shudders and cries out, and, if strong enough, tries to escape. Try to use calm, kindly persuasion instead of force or argument. Tell him the unpleasant effects are only momentary.

We need to remember in choosing which bath should be used that “the rapid application of a low temperature is more refreshing and stimulating, though not more heat-reducing, than the prolonged application of a bath of higher temperature.”

Chilliness, blueness of the hands, and even a small pulse are not sufficient indications for discontinuance of a bath, but chattering of the teeth and blueness of the face are. These latter manifestations are not likely to occur if the friction and chafing

are properly kept up, and the water is kept in motion. Redness of the skin which was at first pale shows that the chafing is having the desired effect. After removal from this bath, the restless patient usually sleeps. Prolonged shivering shows that the bath has not yielded the desired results, owing to some defect in its duration, in the temperature, or in the technique. Subsequent baths should then be of shorter duration and of higher temperature, to conform to the patient's feeble reactive powers. If the cold bath has had the desired effect in fever patients, the pulse, though small, and even almost threadlike, will be found to have gained in force and tension, and it will continue to gain.

*Graduated Baths* are similar to the Brand bath about to be described, with the exception that, instead of putting the patient in the lowest temperature at the start, he is put in water from 90° to 86° F., and cold gradually added, while the warm water is removed. While more agreeable to the patient, this bath is harder to apply, more fatiguing in the long run, and less efficacious as well.

In all baths where the temperature is modified after the patient is in the bath, take great care that neither the hot nor the cold water is added so that it comes intimately in contact with the body. If ice is added, let it be done quietly, by lowering it into the water in a towel, and thus moving it back and forth in the tub so that the patient does not see it.

The *Cold Full Bath* is administered as follows: Give the patient a glass of hot milk (with stimulant, if ordered). Undress him and place a diaper around the loins, and a narrow, dry, handkerchief bandage around the head, with a knot at the nape of the neck, to form a gutter for the water to run off. Bathe the face in cold water. Have the patient step (or if feeble, lift him) into the bath, previously drawn, the water at a temperature of 90° to 65° F., as ordered, two persons gently lowering him into the water, which should come up to his chin. Reassure him as he gasps and tries to escape, by kindness, firmness, and encouragement. Support his head with your hand, or let it rest upon the head strap or air cushion. A water cushion ring for the buttocks adds to his comfort and support. Practice unremitting gentle friction or chafing over successive parts of the body ex-

cept the lower abdomen. *Chattering of the teeth is always a sign for removal*, also blueness of the face, but not necessarily of the hands. Several times during the bath gently pour a basin of water at 50° F. over the head, taking care not to let it run down the face. The time occupied should be from ten to fifteen minutes. Lift the patient out, drop the loin covering, and place the patient upon the bed which has been previously prepared as follows: A double blanket spread on one side of the bed, a pillow covered by a towel and placed under the blanket. Spread a sheet, preferably linen, upon the blanket. Place two hot-water bags at the feet. Lay the patient upon the sheet, bring it around him, pressing the folds between the arms and the chest and between the lower extremities, so that no wet surfaces of the body touch each other. Wrap the blanket around him. If the temperature is above 103° (rectal), let the patient remain in the sheet ten or fifteen minutes. If lower, dry at once with a sheet and towels.

The *Warm Full Bath* (90° to 100° F.) is chiefly of use in reducing temperature, especially in children, in allaying nervous irritation, and so acting as a sedative in insomnia, and in lessening pain.

The *technique of the warm full bath* is as follows: Fill the tub full of water at 98° to 100° F., adding hot water from time to time to maintain the desired temperature. Keep the patient immersed up to the chin. Do not employ friction. Let the patient's head rest upon the head strap or support it. Continue the bath twenty-five to thirty minutes or longer, as ordered. Dry the patient between cotton sheets. Place a hot-water bag to the feet if necessary. If higher temperatures are used, place cold turbans around the head during and after the bath.

*Hot Baths* are given to induce free perspiration, especially in cases where the kidneys are not acting freely. They are given in convulsions of children, for influenza, for insomnia, and many other conditions.

A prolonged hot bath raises the temperature, causes palpitation of the heart, a full pulse, superficial breathing, vertigo, nausea, and collapse. Frequent hot baths cause reduction in weight. Very hot baths (110° F.) after marked muscular exer-

tion remove fatigue. In dysmenorrhea, hot half-baths (100° to 110° F.) for twenty minutes frequently afford great relief. In cases of bronchitis, nephritis, and rheumatism, hot baths are often very useful. Patients with hardened arteries and cases of angina pectoris should not take hot baths.

It is of the utmost importance that all details be prearranged, so that no delays and no thwarting of the object to be attained can occur.

Fill the portable tub half full of water at 100° F., and draw it to the bedside. (If a portable tub is not obtainable, have plenty of warm blankets ready to cover the patient so that transition from bath to bed does not interfere with the effects desired.) Put the patient in the tub, and gradually increase the temperature of the water until the thermometer registers 110° F. Keep a cold turban or an ice bag on the head during the bath, and watch the pulse. If the patient shows sign of faintness, remove him immediately to the bed. Unless otherwise ordered, if all goes well, maintain this temperature from ten to fifteen minutes, then lift the patient into the bed, which has previously been protected by a rubber sheet. Wrap him in three or four hot blankets, tucking them closely about the neck and feet so as to prevent the access of air. Give copious draughts of water. Keep up the sweating for an hour, then gradually unwrap the patient, sponge him under a blanket with alcohol and cool water, and remove the wet blankets.

**Vapor Baths, Steam, and Hot Air Baths.** — Vapor baths are given with special apparatus, or they can be given with one improvised for the purpose.

If the patient is able to sit up, the vapor bath can be best administered that way, otherwise it can be given in bed. A cane-bottomed chair is used. In the sitting position, the nude patient is covered in on the chair with a blanket which is fastened closely around his neck and draped about him and the chair to the floor, so as to prevent the access of air. Putting the feet in a hot foot bath under the blanket increases the effect. For the hot-air bath an alcohol lamp set in a tin basin underneath the chair is then lighted, and the patient kept in that position till he perspires freely, cool drinks being given meanwhile, and a cold

turban surrounding the head. Or, if a vapor is desired, a kettle of boiling water may be placed under the chair.

If the bath is given in bed, protect the bed with a rubber sheet over which a blanket is spread, and upon that place the nude patient, having him lie on one side. Arrange bed cradles with barrel hoops which extend from one side of the bed to the other, if no regular bed cradles are at hand. These support the blankets and the rubber sheet which are to cover the patient's body and exclude the air. Leave a small opening at the foot of the bed (unless the bed has a high footboard, in which case the opening will have to be made on the side well toward the foot) where the spout of the teakettle, or better still, a funnel-shaped, long tin spout, which is attached to the spout of the teakettle of boiling water, is introduced. The kettle is to be placed upon a chair or stool at the foot of the bed. It is kept boiling by a gas, oil, or alcohol stove or lamp. If the water becomes exhausted in the kettle, it must be replaced by boiling water so as not to have the supply of steam interrupted during the procedure.

Take pains that the blankets are tightly fitted around the funnel so that no cool air reaches the patient. The vapor or hot air should enter on a plane above the patient.

In giving this bath to the insane, and, in fact, in all cases, constant watchfulness needs to be exercised not to burn the patient by allowing the hot funnel to slip and touch the body, not to let the blankets become ignited from the flames of the lamp, nor to let the lamp or water be upset.

The bath may be continued from one half to one hour, or until free perspiration is secured. The pulse should be taken at the temples, thus avoiding uncovering the patient. At the end of the bath, sponge the patient as after a hot bath.

The *Continuous* or *Hammock Bath* requires a special bath tub, or at least a special apparatus for an ordinary bath tub, so that the patient may lie comfortably under water, but supported by a sheet or a frame, as in a hammock. He needs to be made thoroughly comfortable, and may be kept in the bath from two hours to all day and night, or even for weeks, only removing him to anoint his skin twice a day or to let him empty the rectum and bladder when necessary.



The sense of chilliness first experienced upon getting into the bath soon subsides and gives way to comfort. The continuous bath is especially efficacious for nervous and mental cases where there is a great deal of irritation, shown in increased excitability, in paralyses, in bed sores, in suppurating wounds, and in many spinal-cord affections, in articular and muscular rheumatism, and in chronic diarrhea and cystitis.

Before applying the continuous bath, anoint the patient's skin, except the face, with mutton suet or cocoa butter to prevent peeling or puckering. Fill the tub with water at 100° F. Lay the patient, clad in a shirt or chemise, on the suspended sheet, which just clears the tub bottom. A rubber pillow should be used. Keep the water near 100° F. by the addition of warm and the removal of cooled water. Never allow the temperature of the water to fall below 95° F. Cover the tub with a blanket. The patient is to be left in the tub for short or long periods, as ordered. If he sleeps, watch that his head does not sink in the water. On no account is he to be left unobserved.

**Compresses.** — Compresses are local wet packs, and if the technique of general packs has been grasped, there should be no difficulty in understanding how to apply a head, throat, chest, or abdominal compress. In general, cold applications help to allay inflammation, and hot applications to hasten suppuration if it is unavoidable. When inflammation in a part is superficial, thin compresses are used; they are applied frequently and are not covered, but when one wishes to affect the deeper tissues, the compress should be thicker, and allowed to remain unrenewed longer, acting more as a fomentation as the cold compress becomes heated and steaming from the tissues beneath.

The *throat compress* is used in tonsillitis, diphtheria, and for tracheal and laryngeal disorders. Unless properly applied, it slips away from the parts needing it, and is then worse than useless.

Select a piece of thin old linen long enough to reach below the chin from ear to ear, and wide enough to form a pad of four thicknesses. Next, take a piece of flannel eight by twenty-four inches, and cut slits in it for each ear, fitting the linen and the flannel to the patient's head before wetting the compress. Then

wring the compress out of water at 60° F. and lay it upon the middle of the dry flannel. Place the wet compress under the chin and unroll the flannel bandage from the top of the head, passing it over the right side of the head; let the right ear come through the slit, pass under the chin to the left side, letting the left ear protrude, then draw firmly over the head and fasten with a safety pin. Have two sets of bandages, so that one may dry while the other is in use. In restless patients, make a circular turn around the forehead for greater security.

The *chest compress* is used by some physicians in congested conditions of the lungs, by others in the later stages of pneumonia only, and in phthisis, when cough and dyspnea are marked. Its value in fevers as a means of reducing temperature is great.

The chest compress is made by folding old linen in three or four folds to fit the chest from the clavicles to the navel in front, and a corresponding position behind, with slits under the arms deep enough to admit of the flaps on each side covering the shoulders. Two such jackets should be made, and two pieces of thin flannel, somewhat larger, should likewise be fitted to the patient.

Roll up the compress and soak in water 60° F., wring out just enough so that it does not drip. Spread out the flannel upon a flat surface and put the wet compress upon it. Roll both together halfway. Gently turn the patient, whose chest is bared, upon his left side, place the compress and flannel on the bed so that the rolled part lies close to his left side, and the lower edge of the left slit is under the left axilla. Then turn the patient gently upon his back so as to release the rolled-up part; unroll this, and then bring both edges of the compress forward on the front of the chest. The flannel cover which has been lying on the bed, under the compress, is then brought over the compress and pinned in front and upon the shoulders with safety pins.

In changing chest compresses (which should be done every thirty minutes while the temperature remains above 102° F., and every hour while above 99.5° F.), be careful to have the second compress ready and rolled before removing the other one, so there will be no delay in the procedure. These compresses need to be changed night and day unless the patient is asleep.

Care must be taken to keep the compresses clean by rinsing them thoroughly in clean water before rolling them in the water at 60°.

Where it is desirable to have the effects of a *fomentation*, in cases of insomnia or other conditions of nervous excitability, the temperature of the water may be higher than 60° F., the compress may be left more moist than as before described, and may be allowed to remain on two hours or more, as the physician directs.

The *abdominal compress* is used in typhoid fever, gastritis, inflammation of the liver, peritonitis, appendicitis, and in intestinal troubles of children and adults when accompanied by fever. It is made of three folds of linen of a size and shape to extend from sternum to pubes and lap over on each side of the abdomen. This is wrung out of water at 60° to 70° F., and held in place by a wider flannel bandage bound around the body and pinned in front with safety pins. It is not necessary to remove the flannel binder when the compress is removed unless it has become dampened. Two sets should be supplied if possible. If each compress is boiled once daily, there will be little danger of the formation of boils. Protect the bed with an extra sheet folded under the trunk. Sometimes, instead of the compress merely covering the abdomen, it is put all around the trunk, with a double layer over the abdomen. It is then called the *Neptune girdle*, and when to this girdle is added a rubber coil on the abdomen, with hot water circulating through it, it is called the *Winternitz Combination Compress*. This is used in cases of obstinate vomiting, and in various gastric conditions, also in painful menstruation, peritonitis, and the like. The Neptune girdle has been found useful in cases of insomnia.

The *Hot Fomentation Compress* consists of two pieces of flannel eighteen inches square, saturated in boiling water and wrung out by a wringer, or, if none is available, wrung out dry in sheets. Anoint the parts to which it is to be applied with cocoa butter or olive oil to prevent burning, then wrap the patient in a dry blanket pack. Open the blanket enough to slip in the fomentation, untwist the sheet, and quickly place the hot flannels upon the affected part and close the blanket again. The extreme heat, which may be unpleasant, is of very short

duration, but your tact will be needed to persuade the patient to endure it. If these hot compresses are applied every ten or fifteen minutes, after three or four applications one has a vapor bath. On discontinuing, gradually unwrap the patient, dry each part thoroughly, then quickly sponge off with water at 75° F., and after friction and drying, put him in bed. This compress is of great value in sciatica, lumbago, intercostal pain, and other rheumatic muscular affections.

**The Douche.** — The Douche is the application of water, under pressure, to a given part, by means of a rubber hose connected with the water supply, the nozzle attached to the hose admitting of coarse or fine jets, or a fan-shaped douche. Then there are rain or shower douches, circular douches (needle bath) and ascending douches.

By means of the douche, water may be applied at a lower temperature speedily, and the result of stimulation and invigoration thereby more easily attained than by some of the hydriatric measures previously described. Only certain parts of the body receive the water at one time, so that the system is called upon to react more gradually than in a cold bath. The disagreeable impression is thereby lessened, and in any case it is "all over in a minute," for a cold douche (below 55° F.) should never exceed one minute, and should occupy from ten to thirty seconds only upon any part. The skin should react by a rosy hue.

One of the chief uses of the douche is to relieve muscular fatigue and to increase the resisting power of the muscles so that they are capable of doing better work; persons of lax fiber, of sedentary occupations, are especially benefited by it. In the douche the water acts as a kind of massage, only much more efficaciously. It improves the circulation, the digestion, and the nerve tone. Anemia and chlorosis, neurasthenia and gastric ailments are benefited by this treatment.

*Scotch douches* are alternating streams of hot and cold water rapidly played upon some part. The physician should direct the temperature, the duration, and the pressure to be used for each case. It is important that enough pressure is used to set up a reaction, or chilliness, depression, and muscular pains will be likely to follow.

**Sitz Bath.** — In the sitz or hip bath, the patient sits in an especially arranged tub of water, so that only the pelvic portion of the body is submerged, the water reaching as high as the navel. The head is enveloped in a turban. Fill the tub half full of water at the prescribed temperature. The patient then sits in the tub, the legs hang over the edge in a comfortable position, and the feet are supported on a stool if necessary. They should be wrapped in a blanket, and a hot-water bag placed under them if the patient is chilly. Add more water of the required temperature, pouring it in rapidly without its touching the patient, while he keeps up active friction on the abdomen and the thighs, an attendant meanwhile keeping up friction in the lumbar regions and sides. As a rule, the temperature for hip baths is from 50° to 60° F., and their duration ten to twenty minutes.

In obstinate diarrhea cold hip baths are often used, preceded by energetic wet-sheet rubbing. For prolonged and profuse menstruation they are prescribed at 85° F., to last from five to eight minutes, followed by the circular bath and then by douches at the same temperature. They are continued daily till the flow ceases. Prolonged cool hip baths are sometimes used in diarrhea, dysentery, cystitis, and uterine hemorrhage. Prolonged warm hip baths (95° to 100° F.) are beneficial in certain forms of dysmenorrhea. A temperature of 70° to 80° F., with friction, is used in chronic uterine and vaginal derangements. Brief cold hip baths are prescribed for prolapsus of the anus and uterus, and for leucorrhea and constipation; prolonged cold hip baths for hemorrhages of any of the pelvic organs, especially for hemorrhoids.

**Irrigation.** — By irrigation is meant the application of water upon surfaces or in cavities. We speak of irrigation of the stomach as *lavage*. In infants this is sometimes necessary in obstinate disorders of the stomach and intestines. Whenever it is necessary to resort to this procedure, see that nervous and unduly impressionable persons are excluded from the room.

Put a quart of water (95° to 100° F.) in which a teaspoonful of salt or of bicarbonate of soda is dissolved in a fountain syringe. Connect the syringe tube by means of a small piece of glass



tubing to a No. 8 Nélaton or Jacque catheter. Gently but firmly press the catheter either through the pharynx or the nose into the child's stomach, the child being held upright by another person. Sometimes the child gets cyanotic, but if the catheter is in the esophagus and not in the air passage, this is of no consequence, though rather distressing to witness. You should introduce the catheter before connecting the syringe. When the child vomits the water, disconnect the catheter and allow the stomach débris to pass out, holding the tube near the mouth to prevent its being displaced. When done, pinch the catheter and withdraw rapidly, holding over the basin and letting go to let the contents of the tube escape into the basin.

**Lavage for Adults.** — Place the patient upright in a chair with the head thrown back, and the clothing protected by a rubber sheet. Place another chair in front of him. Select a large, firm, but soft rubber stomach tube. Have two to six quarts of water ready. Place a basin in the chair in front of the patient. Remove artificial teeth. Stand on the right of the patient, dip the lower end of the tube in warm water, hold it like a pen, introduce it over the tongue, trying not to touch the tongue. When the tube strikes the back of the pharynx, tell the patient to swallow and bend the head forward. Gagging may take place, but reassure the patient; in fact, tell him beforehand of the liability of gagging and vomiting, and that he must keep the mouth open. If the tube meets with obstruction at the cardiac orifice, pouring warm water into the funnel will relax the spasm, and the tube will pass down. You may have to move the introduced portion back and forth, but avoid this if possible, as it causes gagging. When the tube is introduced to the line mark, have an assistant hold it near the teeth, the mouth being kept open. Be sure that the tube is not in the trachea before pouring in the water. This is poured into the funnel connected with the tube. If the patient does vomit, have him lean over the basin and allow the *vomit* to flow through the tube. After introducing about a pint, the funnel is turned down into the basin to form a siphon, while the water is still flowing. When the water runs free, grasp the tube firmly in front of the teeth and withdraw quickly.

*Irrigation of the Intestines* with a large quantity of water by means of a long rectal tube is called intestinal irrigation or *enteroclysis*. The object is usually to distend and cleanse the passage, being different from the ordinary small enema of warm water (containing soap or other ingredients) which is injected by means of a short rectal tube for the purpose of producing an immediate evacuation of the bowels. Flushings of the intestines are also used to stimulate the kidneys to action. In such cases the patient should continue to lie down and should retain the water, that it may be absorbed.

Intestinal irrigation is accomplished by means of the largest-sized Nélaton catheter, attached to a fountain syringe, containing one or more quarts of water that has been previously boiled and partly cooled. Place the patient upon the back upon the protected bed or upon an enema cot, arranging a rubber sheet which falls into a tub or receptacle below, acting as a gutter for the water as it comes away. Protect the floor round about. Anoint the tube, hold it between the thumb and index finger and introduce it into the anus, after first allowing the water to run off into the waste receptacle until it runs warm. Gently but firmly press the tube up into the intestinal canal. If the tube meets with an obstruction, withdraw it a little and gently insinuate it upward. By allowing the water to flow and distend the bowel, the process is often made easier. When the upper part has reached the transverse colon, or when it has gone as far as it will go, providing it has not become curled on the way, hold the tube in place until about two quarts of water have been injected. If there is entire stoppage of the flow, or an immediate return through the anus, you may suspect that the tube is doubled in the rectum. The temperature of intestinal irrigations may vary from cool to hot, the warm or hot being most often prescribed, as they produce the best results.

*Irrigation of the Bladder* is done by a double-current catheter, or by an ordinary catheter, attached to a fountain syringe. The temperature of the fluid to be used should be about 110° F. The clean catheter, anointed, is slowly introduced. The urine is allowed to drain off, after which the water is allowed to flow into the bladder until a slight feeling of distension is noted, or

until about a quart of water has been introduced. The procedure differs in details according to the apparatus used.

*Irrigation of the Vagina* is used for cleansing purposes and to reduce inflammation. A douche pan and a fountain syringe are needed. The patient should lie in the recumbent position. The temperature and quantity of water used vary according to the results to be sought. The perineum should be anointed before introducing the nozzle.

**Foot Bath.** — If the patient is able to sit in a chair, the foot bath can be given easily in that way, but if not able, have the patient lie on the back, bending the knees and placing the feet in the foot tub which rests on the bed, having been introduced at the foot of the bed by loosening and lifting the clothes at the end. The bed should be previously protected with a rubber sheet, and care should be taken that the tub is evenly placed, so that it will not joggle. If the patient is sitting up, wrap the knees and the foot tub in a blanket.

Foot baths are often prescribed for colds in the head, congestive headaches, delayed menstruation, and the like, the purpose being to bring a freer flow of blood to the extremities and thus equalize the circulation. Simple hot foot baths are also used for sprains. When mustard is added to the bath, use about one and one half teaspoonfuls to one gallon of water, first making a paste of the mustard before adding it to the bath. The water should come at least halfway up to the knees. The bath may continue ten to fifteen minutes, adding water from time to time to keep it at the original temperature. After the feet are removed and dried, wrap them well in a blanket.

*Medicated Baths* are sometimes used — mercury, vinegar, bicarbonate of soda, sulphuret of potassium, bran, starch, etc., being added to baths as prescribed by the physician.

## CHAPTER IX

### THE PREPARATION AND SERVING OF FOOD

NEXT to seeing that patients have food of good quality and in sufficient quantity, the nurse needs to attend to its being served regularly and invitingly, in the pleasantest surroundings and under the most favorable conditions procurable.

A contented mind and a cheerful disposition go a long way toward aiding digestion. Whatever interferes with these, unfavorably affects the nutrition. Petulance, anger, envy, hurry, worry, remorse — these are all enemies to digestion. How important is it, then, that the dining-room attendants and the nurses in the hospital departments, where trays are served, make it their conscientious care to reduce these unfavorable influences to a minimum. In the dining rooms, tactful supervision is necessary to prevent the beginnings of contentions; in the hospitals, care is required to secure as much freedom as possible from disagreeable sights or odors. The ventilation of the hospitals before and at the meal hour is all-important; the doors to the water sections should be kept closed; unsightly patients should be screened as far as possible; in the tubercular wards, sputum cups should be put out of sight for the time being. In the dining rooms, patients who are disturbed habitually, or who are disgusting in their habits, should be reported; permission will often be given to serve such patients with trays in their rooms. Care should be exercised in seating congenial persons together and in separating antagonistic ones. The efficient dining-room attendant will take pride in making her dining room attractive by attention to ventilation and to the regulation of the temperature, by admitting plenty of sunlight, by scrupulous order and cleanliness, by such adornment as she can obtain in the different seasons, — wild flowers, grasses, autumn leaves. She will look to the

supply of linen and dishes; will keep the former well mended and as fresh as possible at all times; will try to prevent nicks and cracks in dishes; will see that they are thoroughly washed, rinsed, and dried; will keep the silver and glassware polished, the chairs and furniture in good repair; and the supply of napkins always adequate, so that a shortage does not occur, occasioned by her delay in making out timely requisitions. The same thing holds true in regard to the staple supplies — sugar, salt, butter, and the like.

It is the duty of the dining-room attendant to keep the refrigerator clean, to prevent the accumulation of food that would vitiate butter or milk. Nothing should be allowed in the heaters except the food to be kept hot and the plates, vegetable dishes, platters, etc., which are to be put there long enough before meals to admit of their being thoroughly heated for the serving of hot food. These dishes and the hot food should not be removed from the heaters until just before or after the patients are seated at the tables, else your efforts at heating them will be thrown away.

Special diets, and also the extra food provided by relatives, should be conscientiously served to the patients for whom they are intended, and care taken that they are not purloined by dishonest or mischievous persons.

The dining-room attendant is directly responsible for answering the bell of the dumb waiter, for keeping the door to it locked, for keeping the knife drawer always locked, except when taking things from or putting them into the drawer. She should make it a routine matter always to try the lock after turning the key. She is to exercise the utmost care in using the carving knife and fork and bread knife, not to let any of them out of her hand for an instant, except to lock them in the drawer. She may make no excuse that the dumb-waiter bell was ringing, or that she knew the patients near by were to be trusted, or that she left them, thinking some other nurse would watch them. These excuses will not be accepted for infringement of this rule. She is to keep in the knife drawer a list of all the articles contained in it; her list must show the number of knives, forks, and spoons of any kind that are in her department. All knives, forks, and spoons



are to be gathered up and counted before the patients leave the dining room, and if any are missing, thorough search must be made before the patients are allowed to disperse. Failing to find the missing article, the fact must be immediately reported to the supervisor.

After the patients are seated at the table, the dining-room attendant and those who assist her in the serving of meals should extend the most courteous and watchful assistance to the assembled patients. Patients who are wasteful, and those who are greedy and serve themselves too abundantly, should be served by the nurses with *enough*, but only enough; this is not only to prevent waste, but to prevent overfeeding. Some patients, unless watched, will help themselves to enormous quantities of food, while patients who are of retiring dispositions, or who are depressed or indifferent, will not take sufficient food even if it is there to take, and others cannot if the greedy ones appropriate the lion's share.

Much can be done, by example chiefly, and also by precept, to train certain ones who need it to better table manners than they voluntarily show. Every dining-room attendant should be conversant with the ordinary rules for waiting on table and serving food; she should know how to lay the table in the proper way; should pass things from left to right, and should have a care not to fill cups, glasses, or any dishes to their utmost capacity.

Patients with dainty or capricious appetites need especial care. Do not discourage them by piling too much on their plates; coax them by the daintiness with which you serve their food; if there is any choice, select the best dishes for them, dishes without nicks or cracks. Remember, if you can, the likes and dislikes of the various ones. Certain patients are more susceptible to these little things than others, and the discerning nurse will be quick to see what ones she needs to cater to especially, always bearing in mind, however, that she is not to show what could be construed as favoritism to any. Patients with loss of appetite or poor appetites should be regularly reported to the charge nurse. If you notice that they have poor teeth, call attention to this, and take especial pains to select for them suitable food. Watch the weight lists from month to month of the patients in your depart-

ment, and set about to see what you can do in each case, where an undesirable loss of weight is noted, to remedy the condition.

Food comes to the wards in large quantities in covered tin boxes and cans. When cooked in such bulk and so distributed, it cannot present an especially tempting appearance. It is the duty of the nurse to serve it so that it is as tempting as possible to the patients. Do not hurry patients at meals. Remember the importance of thorough mastication and insalivation and a cheerful atmosphere. Do not urge all patients to eat, whether they are hungry or not. Sometimes it is well, especially for well-nourished persons, to go without a meal or two if the appetite is wanting. But urge all your patients to chew their food thoroughly, to drink all liquids slowly, and not to wash down their food by drinking while they have food in their mouth. On no account are patients to be allowed to take food away from the table.

Patients in the hospital departments require food which can be easily digested. Liquid nourishment is there used more abundantly than solid food. Milk is an almost ideal food to supply the tissue waste in these patients. It contains albumen, fat, sugar, water, and inorganic salts. If patients cannot take it plain, hot milk salted, and perhaps diluted with plain or effervescent or lime water, or with a little cooking soda, will remove the real or fancied difficulty, or peptonized milk may be given. Buttermilk, koumys, whey, broths, soups, and meat jellies are important articles of diet in these cases; also the white of egg, beaten to a froth, strained and mixed with an equal quantity of water and flavored with a few drops of lemon juice.

Punctuality in serving meals to hospital patients is even more important than it is to those who go to the dining rooms. The nourishment is, in many cases, given oftener than at the regular meal hours, and should be served punctually, according to directions in individual cases, the nurse in charge keeping a list with specific instructions as to the kind of food, the quantity, and frequency of serving.

Patients who are given food while in bed should be placed in as comfortable a position as possible. Bed trays or bedside tables should be used wherever they are to be had, and the trays

and all food and dishes are to be removed as soon as the patients have finished with them. Fruit is not to be left in the sick room between times, but is to be brought, temptingly prepared, at the time it is to be taken. Grapes, oranges, and grape fruit should be served cold. Dried fruits, such as raisins, figs, dates, prunes, apricots, may be placed in a small dish on the breakfast tray. They are important additions to the diet. Food meant to be served hot should be hot, food meant to be cold should be cold — no lukewarmness in the matter. Monotony is to be avoided, both in the kind of food offered and in the method of serving.

As a rule, do not ask a patient what she would like to have to eat. Remember that even a simple surprise will often do wonders to whet the appetite.

As before mentioned, dainty portions beguile patients into eating and often into asking for a second helping, where piling up a dish, or even a moderate serving, may discourage one. In filling cups, glasses, saucers, do not fill to the brim, and always make allowances for possible jarring in carrying the trays, so that even if this occurs, there shall be no slopping over. If chronic or convalescent patients assist in preparing and carrying the trays, they need especial supervision in this respect. If accidents of this kind do occur, carry the tray away, empty the dishes thus made unsightly by spilling, put on a dry napkin, and then serve the tray. The necessary delay is the lesser of the two evils. Never taste a patient's food in her presence. Taste the food in the serving room and reject or rinse the spoon which you so use.

If friends of your patients can afford it, and seem eager to know what they can do to contribute to the patient's comfort, suggest that they send individual trays and napkins, dainty dishes, and all the appointments, having a care to consult the patient's preferences as to color if they are known. These individual touches make your work a little harder, perhaps, but the gratification the patient so often evinces will go a long way to recompense you for the extra care.

Sometimes placing a flower — often a simple wild flower — a bit of evergreen, or a bright autumn leaf on the tray, or occasionally a humorous quotation, or one about something concerning which you know the patient is especially interested, will add

a charm it is difficult to estimate unless you have been ill yourself, or have otherwise seen the effects of these gracious little attentions.

Feeble and helpless patients need to be fed by the nurse, also those who are confused, or overactive, or too depressed to eat. Demented patients often bolt their food and gorge themselves. Epileptics are especially prone to this practice. Such cases require careful supervision if not actual feeding. General paretics should always be fed. Even if they appear to have but little difficulty in swallowing, they should not be left alone with a tray, and where the slightest apparent difficulty exists, the utmost pains should be taken to feed them liquid food slowly and carefully.

All feeble patients (in fact all patients) should be fed slowly. The aged and those with poor teeth should have their food especially prepared for them, the meat cut very fine, and special diet should be requested for such as are unable to eat the regular diet provided.

In feeding patients who are loath to eat, try to cheer, encourage, and direct them. Sometimes, by engaging the attention of certain stubborn ones, you can get them to take food almost without their knowing it. Make no comments about this in their presence, continue your cheerful talk and the feeding, and act as though nothing out of the ordinary had happened.

Fill a cup or glass only part full when feeding helpless persons, raise the head slightly and support it firmly, having previously placed a napkin under the chin; then place the cup to the mouth, taking care to tip it just enough, and make an occasional stop for the patient to rest. When feeding cups are at hand, a very weak patient can often feed herself more comfortably than to have the nurse feed her.

If a patient must lie on the back, the simple device of letting her draw up the nourishment through a bent glass tube will prove satisfactory.

Exhausted patients requiring frequent nourishment often need to be awakened to take food; they usually drop off to sleep again.

In feeding unconscious or delirious patients, or feverish ones, first moisten the lips with a swab made for the purpose, dipped in

glycerine and lemon juice. Then pass the partly filled spoon well back in the mouth, taking care not to touch the tongue if you can avoid it; empty the spoon slowly; then close the lips and nostril (of the unconscious patient), and the patient will swallow. Or the food may be dropped on the tongue with a pipette.

Always wipe the corners of the mouth and the lips of helpless or careless patients during and after eating. The hands of bed patients should be washed before trays are carried to them; and the faces and hands, the bed and bed clothing made tidy again after the removal of trays.

If patients are fed in bed, special care should be taken not to drop crumbs in the bed; if they feed themselves, this cannot be so well regulated. It is, therefore, important in the majority of cases that the nurses attend regularly to the removal of crumbs (and wrinkles) from the bed after each meal.

Trays filled with glasses of water should be passed regularly in the hospital departments between meals, and the patients persuaded, urged, required, as the case may be, to drink the water. In some few instances, especially in failing heart troubles, the drinking of water, except in small quantities, may be contra-indicated. Such patients will doubtless be singled out by the physician as exceptions to the general rule.



## CHAPTER X

### PRACTICAL POINTS IN NURSING THE INSANE

I SHALL take it for granted, in touching upon the topics in this chapter, that the nurse is already conversant with the details of the various procedures in question, details which she is supposed to have learned from text-books on general nursing, from lectures in the Training School, and from instruction and practice on the wards. The procedures I particularly have in mind are the best methods of giving enemata and douches, of irrigating the uterus, of washing out the bladder and the stomach, of administering medicines, making local applications, and applying massage.

I shall merely refer to some of these and to a few other topics, in order to supply some details with special reference to the needs of the insane.

In all these procedures the aim should be to do them deftly, with the least possible pain or discomfort to the patient, so as to secure the best results. Owing to the added difficulties that the nurse of the insane encounters, it is of even more than usual importance that everything needed for a given task be in readiness before the actual work with the patient is begun. An excited, resistive, or otherwise obstreperous patient is usually made more so by watching the haste and bustle of preparation, while if necessary preparation is neglected, and, in the midst of what is a trying task at the best, there is added the delay of waiting while some one who can be ill spared runs to hunt up necessary things, it is easy to see that confusion will reign, and perhaps failure be the result.

**Enemata.** — It is frequently necessary to give insane persons enemata to secure an evacuation of the bowels and to control dysentery. Enemata are less frequently given for other purposes.

One should never set about this without explaining, to all patients at all capable of appreciating it, what is to be done, and why. Time will be saved and resistiveness and violence often avoided by painstaking explanations. Especial care needs to be exercised to avoid injuring a struggling patient either by letting her become bruised from being held, or from throwing herself off the cot, from injuring the parts by too forcible or by unskillful use of the nozzle, and extra pains have to be taken to explain to the patient the necessity for trying to retain the enema as long as desirable, in order that it will be effectual, and will not need to be repeated.

You will need to assist many patients to retain the enema by holding a folded towel close to the anus.

Some malicious patients will take delight in evacuating the contents of the bowels before the nurse has the pan or other receptacle ready. Some deluded patients, governed by the belief that all their evacuations are of great value, have to be worked with for a long time before they can be persuaded to expel the contents of bowels or bladder. The nurse may need to assist in the emptying of the rectum by manual interference. When this is necessary, she should anoint the index finger of her right hand well with soap, and fill in the space around and underneath the nail with soap, as this prevents the fecal odor from clinging to the finger afterward.

Have a special care that angry and violent patients do not get a chance to pull down the douche can, or tip over basins, or spill or break appliances close at hand.

It is sometimes necessary to give patients nutrient enemata when for any reason food cannot be retained by the stomach, and when nasal feeding is not advisable. Remember that the rectum must be empty before giving the nutrient enema. The nutritive substance is injected through the long rectal tube passed at least eight inches beyond the sigmoid flexure; the hips should be raised on a folded blanket, and the patient required to lie very quiet for at least a half hour afterward. As a rule from three to six ounces of the nutritive fluid, at 100° F., are administered every four or six hours. Beef tea, malted milk, Mellin's Food, eggs and milk, and the like, are given.

The food is very slowly and carefully injected by pouring into an elevated funnel attached to the rectal tube.

**Vaginal Douches.**— In the giving of vaginal douches especial care needs to be taken with struggling patients, as has been enjoined in the giving of enemata. Glass nozzles should seldom be used with patients at all likely to be resistive, because of the danger of their breaking within the body.

**Catheterization and Irrigation of Bladder.**— It sometimes becomes necessary to catheterize insane patients to obtain urine for analysis, to relieve retention, either voluntary or involuntary, and to prevent the flow of urine over inflamed parts, or over parts recently operated upon.

Hot applications over the patient's bladder and the region of the kidneys, a hot sponge between the thighs, sitting over hot water, irrigating the vulva, a sitz bath, a hot pack, or a hot enema are means to be tried before catheterization is resorted to, and even then it is only to be done when ordered by the physician.

The strictest antiseptic precautions in the cleansing of the hands, the cleansing of the parts, the care of and use of the catheter, in fact, in the entire procedure, must invariably be observed. More than ordinary care is needed in this respect with the insane, and also to avoid injuring patients who struggle during the operation. It is always better to introduce the catheter by sight in the insane than to do so under cover. Never use a catheter which is in the least danger of being torn or broken.

In irrigating the bladder of insane patients, more than ordinary care needs to be exercised to avoid introducing too much water (less than a pint as a rule) without letting it run off, as such patients may fail to complain when pain due to discomfort is felt.

**Use of Stomach Tube.**— It sometimes becomes necessary for the nurse to obtain the contents of the stomach for laboratory examination. In such instances the physician usually orders a test breakfast, specifying the food. It may be simply a cup of clear, unsweetened tea, and one or two soda crackers, or steak and bread and butter. In an hour's time after taking the food the nurse is to obtain the stomach contents by passing the

stomach tube. This tube, on entering the stomach, causes the walls to contract and expel the food. If it fails to do this, pouring down about two drams of lukewarm water will usually be effectual. The contents should be measured and immediately sent to the laboratory in a clean bottle, labelled with the patient's name, the ward location, and name of nurse, the date, the time of the breakfast and of securing the contents, and the quantity.

**Nasal Feeding.** — Forced feeding through the nose is resorted to when a patient's condition, bordering on exhaustion, because of refusal of food or inability to swallow, demands it. Because of some delusion on the part of the patient, or some difficulty in swallowing, the physician may decide that mechanical feeding must be employed.

Insane patients often refuse food because they think they cannot eat, or ought not to eat — perhaps that by so doing they are depriving others — or because they wish to die, and so resolve to die by starvation. A physician should always be present at the feeding, and should pass the tube the first time that this method is tried on a given patient.

The nurse should tax her resources to the utmost before admitting that she cannot get the patient to take sufficient nourishment. One nurse may succeed where another fails; the physician may be successful where the nurse fails; or a tactful patient may overcome the refractory patient when no one else can; or food left about for the patient to take when she thinks herself unobserved may accomplish the desired end. Leave nothing untried before admitting defeat. It is sometimes a good plan to let the patient witness another patient being forcibly fed; in some instances the repugnance aroused is sufficient to overcome the refusal of food. As a rule, though, a patient who is being forcibly fed should be screened from others, except the ones necessary to assist in the operation. Sometimes one feeding accomplishes the desired end, but in other cases the feeding has to be continued weeks, months, years, as the case may be. Some patients lie quietly and submit to the introduction of the tube, some resist frantically, pull the tube out if they can, or regurgitate the food if they cannot succeed in removing the tube. Some will force the tube into the back part of the mouth, in

which case it needs to be withdrawn and reintroduced. In a few instances patients have not only been known to submit willingly to the tube, but even to introduce it themselves. One deluded patient I have in mind argued that since the matter was beyond her control, and she was forced to take the food, though strenuously objecting to it, the Lord would not hold her accountable for food taken in this way, consequently she might as well suffer its injection with as little discomfort to herself as possible.

In forced feeding, always have plenty of assistants at hand, so that the patient sees the uselessness of resistance. Never resort to feeding without explaining to a patient capable of understanding it, that it is the last resort, and that we much prefer that she take her food by the mouth. Sometimes, at the last minute, with all the appliances and assistants at hand, if a cup of milk is offered, the patient will yield rather than submit to the passage of the nasal tube.

Have everything at hand before approaching the patient — a large towel to use as a bib, a stand on which to set the tray which should hold the feeding bottle with the food, the long rubber tube (size 13 American) for introducing into the nose, the small dish of olive oil for a lubricant to the tube, two or three towels, and an extra sheet. One towel folded lengthwise, so that it is about four inches wide, may be used, if necessary, to hold the head down to the pillow, thus avoiding bruising a struggling patient by making pressure with the fingers on the temples or forehead.

The patient should be slightly propped up on pillows, the clothing about the neck loosened, and protected by a towel or a sheet; artificial teeth, if worn, should be removed, and a sheet placed across the patient's body over the knees, outside the bedclothes, and, if necessary, firmly held on each side by two attendants in order to prevent the patient from kicking or throwing herself about. Another assistant, in cases requiring it, holds the patient's wrists, taking care not to bruise her, nor to exert force unless it is necessary. You need to be on your guard to prevent the patient from pulling out the tube after it is in place, from kicking the assistants, from struggling so that the bottle of food is overturned, and from throwing herself on the



floor. She may also tear your hair, spit in your face, catch at your watch chain or key chain, or apron straps, and show other violent and malicious tendencies.

The prepared food, properly warmed and salted, is brought in the bottle especially used for the purpose, fitted with a pumping apparatus and a long rubber tubing and nozzle, to which the free end of the feeding tube is attached, after the tube is introduced into the esophagus.

The feeding tube may be oiled or dipped into the feeding mixture to make it pass easily; it is then introduced into one nostril, using only mild pressure as it is pushed along the floor of the nasal chamber. Care should be taken not to rotate it. When it reaches the pharynx, it may meet with some obstruction, or it may pass readily down the esophagus, or may, rarely, enter the larynx. Great care is necessary at this point. When the tube meets with obstruction, tell the patient to swallow; if she obeys, it will be sufficient to let it pass; sometimes it will be necessary to withdraw it a little way, then by making slight pressure it will find its way into the esophagus; or you may need to withdraw it entirely and try the other nostril. After the tube has passed down, say about eighteen inches, and there has been no embarrassment, no strangling or coughing, and if you can feel no air coming out at the free end of the tube, you may be sure that the tube is where you have been trying to put it — in the stomach; but if, before passing to such a distance, cyanosis of the face, strangling, or any of the above-mentioned symptoms are noticed, you must quickly withdraw the tube, as the chances are you have introduced it into the larynx. Patients often get very red in the face from struggling, but if the tube has gone down the right way this need not deter you from connecting the free end with the nozzle of the tubing on the feeding bottle, and proceeding to pump in the liquid. This should be pumped steadily and leisurely, watching the lowering of the fluid in the bottle and discontinuing before it gets so low that there is danger of introducing air into the stomach. Quickly disconnect the feeding tube from the bottle nozzle, then quickly withdraw the tube, immediately on its withdrawal gathering it into the towel previously shaken out, not allowing the tube

to trail over the patient's mouth or chin, and taking care, as the tube is removed, to cleanse the nostril from the mucus that is usually seen at the entrance on the withdrawal of the tube. Pinch the outer end of the tube to prevent dripping of the liquid upon the bedding or the patient. Encourage the patient to lie quietly after the feeding.

In some cases it is necessary for an assistant to hold up the lower jaw by pressing up against the angles and the lower border of the jaw, during the introduction of the tube, bending the head slightly backward. It may also be necessary to continue holding the head in this way for several minutes after the feeding, in certain cases, to prevent the patient from regurgitating the food. Persistence in bringing the food up as soon as it is down may sometimes be corrected by repeating the entire process immediately, when the patient, seeing that her conduct will not prevent another feeding, will often desist rather than to have the disagreeable measure repeated.

Various fluids are used in forced feeding — hot milk, Mellin's Food, malted milk, beef tea, milk and eggs with extract of beef, and other nutritious and well-strained mixtures.

It is well to close the feeding by adding four or five ounces of water if the patient refuses water by the mouth, or to add this amount of water to the feeding mixture.

The food should be varied from day to day, and the quantity and frequency regulated by the physician. In the majority of cases, from one and one-half to two pints are given at a feeding.

Milk used for nasal feeding is usually thickened with flour and salted. On some days this is thickened with boiled potato instead of flour, again with beans, peas, corn meal. Sometimes one ounce of the juice of raw potatoes (or other vegetables) is added to each pint of milk used. Prune juice may be added to the feeding mixture. Thick soups and broths of various kinds, diluted with beef tea, so as not to clog the feeding apparatus, are used for forced feeding. The tube should be promptly cleansed in cold water after being used, and the bottle rinsed in cold water, then thoroughly washed and rinsed and made ready for the next feeding.

**The Administration of Medicine.** — In giving medicines to delirious patients they may often be helped to swallow by first moistening the lips and rubbing the spoon against them. Unconscious patients should not be given medicine unless expressly directed by the physician, as suffocation or strangling may result; but when given, it should be placed far back upon the tongue, and in liquid form.

When medicines are given from spoons, the spoons should not be so full as to spill and let the liquid run down the chin. They should be carried with a steady hand, and given from the point of the spoon; a clean towel or napkin should be at hand to wipe the lips, or, in case of resistive patients, to protect clothing and bedding.

The forced administration of medicine should never take place except when so ordered by the physician, nor should medicines ever be put in the food unless so ordered.

Medicines should be given promptly and quietly, avoiding as much as possible letting the patient see preliminaries. Convalescent and able-bodied patients should go to the medicine closet at the prescribed intervals, on signal of the nurse, and bed patients should have medicine carried to them and administered by the nurse, never by a patient, however trusty one may be.

Medicines are to be kept in the locked closets arranged for them. Nothing is to be permitted in these places except such articles as are expressly allowed by the institution in which you are employed. A list of contents, always up to date, should be fastened inside the medicine closet in a conspicuous place for ready reference.

Lotions, local applications, and disinfectants are on no account to be kept in medicine closets, but are to be kept locked in special compartments assigned for their safe keeping. All poisonous medicines must have a conspicuous label indicating the same. No patient, however trusty, is to be permitted even momentary access to the medicines or disinfectants. All medicines are to be transferred immediately from the custody of the drug clerk to the medicine closet, in no instance being allowed to remain elsewhere till a more convenient season. As soon as received, the names of the medicines, the dose, and

the directions for giving are to be transferred by the charge nurse to the nurse's medicine book, under the patient's name. Medicines no longer in use are to be promptly crossed off the book and returned to the pharmacy.

The most conscientious attention must be paid to the administration of each prescription exactly as ordered, unless the patient is sleeping, in which case, if not expressly stated otherwise, it is well not to awaken the patient.

Empty bottles, envelopes, and boxes which have contained medicine, and all medicines ordered discontinued, are to be returned to the drug room.

Unless a medicine is plainly marked with the dose and the directions for administration, the nurse must refrain from giving it, but must report the same to the physician in charge. There must be no guesswork in any instance. If medicine comes to a given ward marked for a patient, but with a mistake in the initials, or in the given name, it may be intended for a patient on another ward; the nurse must ascertain without a doubt for whom it is intended.

Refusal to take medicine, if it cannot be overcome by persuasion, should be reported to the physician, who will direct whether force or subterfuge shall be resorted to for its administration.

In each case of administering a dose you should assure yourself that the medicine has been swallowed. The insane are often very suspicious, especially concerning drugs; they will sometimes resort to all sorts of means to avoid swallowing them. Some will spit them out, either upon the floor or the bedding, or slyly in a handkerchief; others will hold them in the mouth till the nurse's attention is diverted, and then eject them out of the window, behind radiators, down the wash bowls or water-closets. It is a good plan to engage a suspected patient in conversation at the time of administration; inability to get him to reply, unless he is in a stupor, or is a case of mutism, or is actually mute, or too demented to talk, ought to put you on guard to see if he is not rejecting his medicine. If you suspect, or feel convinced of this, it is well not to let him know of your suspicions, but to let the physician know, as the case may require

very careful handling, the details of which the physician will wish to arrange.

It is very important, in applying either dry or moist hot applications to insane patients, to use the utmost care, both in applying and in leaving the applications in place, that the patients shall not be burned. Unconscious, stuporous, paralyzed, and demented patients need to be especially safeguarded in this particular.

**Massage.** — Massage cannot be properly learned except from an experienced teacher, and skill can come only with practice after thorough instruction has been received. The masseur or masseuse should be strong and well, fastidious in person and attire, free from any skin affection, from a bad breath or catarrhal or other objectionable odors, and free from the use of strong perfumes or tobacco. The hands should be strong, soft, and supple, the motions well-defined, purposeful, methodical; there should be no flurry, hurry, jerkiness, or fussiness.

Nervous patients need especially to be taught to relax the entire body as completely as possible, to lie passive, giving the body over, for the time being, to the care of the masseur, only trying to help in so far as to obey is to help. The nervous or mental patient, as a rule, should not be engaged in conversation, nor encouraged to talk, even if he seems so disposed; neither should he be talked to, except a few quiet, cheery words at greeting and parting, and the necessary talk incident to the work at hand. At the close of the treatment he should be allowed to lie quietly in the blanket and rest for an hour, whether he can sleep or not.



## CHAPTER XI

### THE OBSERVATION OF SYMPTOMS

NURSES are with patients so continually and see them under such varying conditions that the help which they can render by intelligent observation is incalculable. But one needs to know what to look for, and to adopt a systematic way of observing a case — needs to know what is normal before the abnormal condition can be recognized.

The general appearance of the patient, including his physical condition, his behavior, habits, and peculiar mental manifestations, are headings under which the nurse may group her observations.

As much as possible should be ascertained without asking questions. It is what you notice that the physician wishes to learn. In most instances it is better to leave the questioning to the physician. Above all, do not be indiscreet in your observations, interrogations, or comments. Be especially considerate concerning deformities, as persons having them are usually sensitive about them.

By symptoms we mean the manifestations of disease or injury. These are classed as subjective and objective. *Subjective symptoms* are those which the patient experiences; we must rely upon him for information concerning them. Great care is necessary in determining how much weight to give to subjective symptoms, for patients, consciously or unconsciously, often exaggerate or make light of their feelings, or even profess to have certain symptoms which they do not have, or deny having those which they do have. We call a person a malingerer who professes to have symptoms which he does not have.

Among the most common subjective symptoms are pain, vertigo, nausea, tenderness, increased sensibility, loss of sensibility, sensations of numbness, crawling, burning, itching, bad

taste in the mouth, noises in the ears, spots before the eyes, an undue sense of fatigue, and the like.

It is the nurse's duty to report all subjective complaints whether she believes them to be real, exaggerated, minimized, or feigned; but if she has good ground for believing them to be simulated, it is proper for her to mention such grounds. Let it be remembered that these very subjective complaints, even when exaggerated or feigned, may be of the utmost importance to the physician. In early cases of mental alienation it is especially important to note the complaints of changes in the organic sensations, for these are often of such a nature as to interfere with the combination of sensations that make up the patient's individuality, and the study of these is often of the greatest help in tracing the beginnings of the alteration of the ego, in other words, of seeing the bridge across which the person passes from sanity to insanity.

*Objective symptoms* are those which may be detected by others. In addition to having acquired by practice accuracy of observation, the nurse needs to learn what symptoms demand immediate attention and what can afford to wait until the physician's regular visit. It is always better to err on the safe side if a symptom seems at all urgent than to fail to call a physician and later find that you have made a serious error in judgment.

Nurses of the insane need to remember how important it is to observe the so-called silent symptoms, for insane persons are often unable to tell when they feel sick or how they are ailing. Only by quiet crying or slinking away in a corner on the floor, or going to bed, or refusing to eat, or in some such way, do certain persons show their indispositions.

For convenience, and in order that a method may be followed in making observations, the following outline of examination is offered:—

Name of patient      Date of observation      Ward location      Name of nurse

#### GENERAL APPEARANCE OF PATIENT

Dress — tidy, untidy, clean, unclean, precise, slovenly, fantastic, fastened imperfectly or carelessly regarding decency; droppings of food; shoes, where most worn, if disorders in gait are noted.

Behavior — timid, reckless, modest, bold, docile, unruly, mild, boisterous, meek, boastful, indifferent to surroundings, interested, overcurious, mischievous, restless, apathetic, occupied, idle, destructive, oversensitive, peaceable, threatening, flighty, poor control.

State of nutrition and apparent or real weight and height — emaciated, slender, well nourished, stout, obese, dwarfish, short, medium, tall, very tall.

Complexion — fair, dark, medium, sallow, ruddy, florid.

Hair — color, texture, quantity, baldness (general or local).

Eyes — color, expression, appearance of pupils.

Facial expression — calm, happy, anxious, worried, suffering, dejected, elated, egotistical, shrinking, pinched, tranquil, dull, stupid, bewildered, besotted, delirious, dazed, convulsed, etc.

Carriage and posture of body — walking, erect, bent, staggering; sitting, erect, stooping; lounging, lolling about, etc.; lying down, apathetic, restless, sliding down in bed, etc. Manner of moving about, impairment of motion, etc.

## OBJECTIVE SIGNS IN SPECIAL ORGANS AND PARTS

Note if there is anything unusual in appearance or condition of:—

Head and face, and organs of special sense; neck or throat; chest; back or abdomen; extremities; genital organs; skin.

## SUBJECTIVE COMPLAINTS

Pain, tenderness, abnormal sensations, numbness, nausea, vertigo, etc. Is pain sharp, dull, burning, stinging, darting, band-like, needle-like, constant, intermittent, spasmodic?

## MENTAL STATE

Intellectual field — conscious, unconscious, dull, alert, rational, irrational, delusions, hallucinations, illusions, hobbies, queer ways, perversions, lapses in memory, fabrications, disorders in speech, misapprehending of persons and surroundings, suicidal or homicidal tendencies, self-accusations, ideas of reference, or of undue or unfair influence.

Emotional field — self-controlled, or rapidly changing and uncontrolled emotions, happy, sad, cheerful, joyous, morose, irascible, signs of affection, love, rage, fear, dread, hopefulness, jealousy, envy, sympathy, merriment, grief, zeal, *ennui*, feeling of unreality, credulity, doubt, aspiration, elation, depression, hesitation, indecision, timidity, anxiety, irritation, contentment, pride, humility, admiration, patience, scorn, rebellion, abhorrence, contempt, disgust, pity, impatience, expansion and ease, or contraction and tension, sensitive to the beautiful, the sublime, the comic, etc.

This outline merely furnishes one with hints as to what to observe, and the general order in which to proceed.

Let it be clearly understood that in your observations you are to take in these things so quietly and unostentatiously, while undressing and dressing, bathing, and otherwise caring for the patient, while talking with her and watching her when she considers herself not under observation, that she gets little or no hint that you are doing anything other than being attentive to her needs.

Sacrifice your observations every time rather than subject the patient to unpleasantness, or incur displeasure or anger, or arouse the suspicion that you are scrutinizing her.

In taking into account the respiratory rate, one needs to remember that it is naturally increased after eating, after exercise, and by any strong emotion. Pain usually increases it; it becomes accelerated with an increased temperature; in hysteria it is often quickened, and it is usually appreciably increased in phthisis. It is decreased in coma, poisoning, shock, and in stupid states, as in dementia præcox.

To count the respirations, watch the rise and fall of the chest or the upper abdomen, or lay the hand lightly upon the lower chest; if one knows that he is being watched, it naturally increases his respiratory rate, so that it is better to keep the fingers on the pulse while determining the respiratory rate, and so let the patient think that it is his pulse instead of his breathing that concerns you. Or count the respiration while taking the temperature, watching the rise and fall of the clothing over the chest.

In preparing a patient for a chest examination, strip all clothing from the chest, and if the patient is strong enough, have him assume the standing position. Wrap a sheet around him until the physician is ready to begin inspection of the chest. The room should be comfortably warm so that the patient does not feel chilled from the exposure. Wash under the arms, drying the skin thoroughly, and if the perspiration is profuse or offensive, dust toilet powder or cornstarch in the axillæ. Have a clean towel ready, and dry any perspiration that may form during the examination. It is very unpleasant for a physician to have to put his fingers in a sweating axilla. Have ready

soap and a basin of warm water and a towel, or at least a clean towel with one end moistened for the physician's use. If the patient's skin is very dry and harsh, it is well to oil it before the examination, to avoid confusing friction sounds. Try to keep the room as quiet as possible during the examination.

Learn to describe fully the character of the various coughs and the appearance of the sputum. Coughs may be dry, loose, hacking, barking, rattling, paroxysmal, suppressed, croupy, etc. Sputum may be watery, blood-tinged, viscid, mucous or muco-purulent, purulent, rusty, like prune juice, or it may consist of clear blood

There are certain symptoms which should make the nurse suspect trouble with the heart and blood vessels. Some of these are difficult breathing, especially if made worse by exercise, and accompanied by blueness of lips and face; swelling of the feet and ankles, palpitation, pain in the region of the heart, anxiety and fear of death, sudden dizziness, restless sleep, starting in sleep, chronic cough, chronic digestive disturbances, and obesity. The nurse should report any of the above symptoms, and should examine the chest for distended veins, pulsations in the large blood vessels of the neck, or in the pit of the stomach, and should note if the apex beat of the heart is especially conspicuous.

The rate and character of the pulse should be carefully studied. The patient should be lying down or sitting, and should not have made undue physical exertion just previous to the taking of the pulse. In susceptible persons the mere act of another's counting the pulse increases its rate, so it is well to let patients get accustomed to your finger being on the pulse before you begin counting for the purpose of recording it. The patient's forearm should be half prone, the tips of the index and second fingers should be placed on the radial artery, which is usually felt pulsating on the outer side of the wrist. There is sometimes an abnormal course of the artery, so that you may have to hunt for the pulsation other than in the usual place. It is better for the nurse to count the pulse for a full minute than to count for half a minute and multiply by two.

Note if the beats are regular, whether they skip a beat occasionally, whether you can feel the artery roll under your finger, or



whether by pressing on the artery the pulse becomes less distinct or not.

If a patient complains of feeling chilly, looks flushed, or acts sick or "dumpish," or refuses food, it is well to take the temperature. For accuracy, rectal temperature is the most reliable. If the temperature in the axilla is 98° F., it will be about 98.6° in the mouth, and 99.5° in the rectum.

It is very necessary to explain what you are about to do to insane patients, and thus avoid frightening or shocking them by these investigations. The temperature should never be taken in the mouth of suicidal or very excited patients, as there is danger of their biting down on the bulb of the thermometer, and of swallowing the glass. When taking mouth temperatures, if the lips are dry and cracked, they should be moistened so that they will fit closely around the stem of the thermometer. Do not take the temperature immediately after the patient has been given hot or cold drinks or cracked ice. When the temperature is taken in the axilla, first dry the skin, then place the bulb well in the hollow, and hold the arm firmly to the side. When rectal temperature is taken, first make sure that the rectum is free from feces, oil the bulb and insert it carefully one and one half to two inches, the patient lying on the side.

In most insane patients it is necessary for the nurse to give her undivided attention to the patient while the thermometer is in place, in order to avoid attempts to break it, to swallow it, or otherwise to thwart the investigation. Always record where the temperature has been taken.

To prepare a patient for examination of the abdomen by the physician, turn down all the bed clothing but the sheet, then, under cover of the sheet, draw the nightgown up as far as the margin of the ribs. When the physician is ready, fold the sheet down to just above the pubes. Have the patient lie on the back as evenly as possible, and let the light fall upon the abdomen. In obese patients, be particular to bathe, dry, and dust the skin under the mammæ and under the fleshy and pendulous parts of the abdomen, as these parts lying in apposition become moist and often offensive unless care is used. Have warm water, soap, and a towel ready for the physician's use.

If there is vomiting, ascertain whether the *vomit* consists mainly of food, or whether the ejection of food is followed by a watery or mucous substance, by bile, blood, fecal matter, or worms, or whether it has the odor of any drug.

The nurse needs to watch her patients while they eat in order to learn whether they chew their food sufficiently, or bolt it, whether they eat with apparent relish or force themselves to swallow each mouthful; what food seems most acceptable, what most distasteful. She should note and report a capricious or ravenous appetite, and should observe if eating is accompanied by apparent discomfort, nausea, or vomiting. Is the refusal of food apparently due to loss of appetite, or to delusions?

By *anorexia* we mean loss of appetite; *bulimia* is increased appetite, and *pica* is depraved appetite for unwholesome, indigestible, and disgusting things — a condition sometimes seen in pregnancy, hysteria, anemia, and often in idiots, and in the insane.

It is the duty of the nurse of the insane to acquaint herself with the regularity and frequency of the bowel movements and the appearance of the stools of every new patient who comes under her care, and these investigations should extend to the older cases, even though in a lesser degree, especially in the deteriorated class of patients who are incompetent to attend to and report concerning themselves in this particular.

Constipation may be due to the insufficient taking of waste material in the food, to a too scanty ingestion of liquids, to overdistension of the intestines with food, to stupid states, to dependence upon cathartics and enemata, to hernia, to intestinal obstruction, and to many other causes. One of the most frequent causes of this symptom is neglect and laziness on the part of the patient — a failure to train the intestines to regular habits of evacuation.

Diarrhea may consist of only three or four loose stools in twenty-four hours, or it may present all degrees from this to the almost continuous purging of dysentery. Like constipation, it may be caused by a great number of conditions. These may be psychic as well as physical — emotional shocks, anticipations, pleasurable or otherwise, unusual events may give rise to it,

especially in neuropathic persons. Inflammatory conditions of the intestinal tract are the most common causes of diarrhea, and these may be brought about by many and varied things.

The nurse needs to remember that the patient may have diarrhea and still be constipated. The feces may collect in hard masses in the colon and yet a channel remain so that a loose stool passes, the result of the irritation to the mucous membrane caused by the hardened masses. An accumulation of feces in the abdomen is usually discovered by the doughy feel to the mass, which can be indented as a rule. The passage of hard fecal masses (*scybala*) should always make one suspect constipation.

Stools may be formed, fluid-fecal, semi-fluid, or fluid in consistence. Milk diet makes them light yellow; clay-colored stools indicate a deficiency of bile, green stools are not uncommon in the diarrhea of infants, and after calomel, or where there is an increased secretion of bile; black stools may be due to the use of iron or other drugs; blood in the stools may give a red or tarry color. As a rule, bright red blood in the stool comes from the rectum, from hemorrhoids, fissures, or ulcers, while tarry stools show the origin to be higher up, and probably due to gastric or intestinal hemorrhage. In the insane, when blood in the stools is noted, we should suspect the presence of foreign bodies in the rectum, causing irritation. When we reflect that a rubber heel, a key chain, false teeth, and other incongruous articles have been extracted from the esophagus of patients, that an ordinary silver teaspoon has been found in the intestines of a patient at autopsy, and that a five-inch iron bolt has been found in the cecum at operation, and that masses of hair, rags, ravelings, and other foreign bodies are frequently found in the stomachs and intestines, and sometimes in the vagina, at autopsies, we need to be constantly on guard to see that the rectal and vaginal passages are not furnishing hiding places for foreign bodies.

Urination may be natural, painful, difficult, slow, frequent; there may be incontinence, retention, suppression. Painful urination is most frequently due to inflammation of the bladder (cystitis), but may also be due to growths or ulcerations of the bladder or of the urethra, to stone in the bladder, gravel, and

other conditions. Difficult or slow urination is due to any condition that obstructs the urethra or impairs the muscular power of the bladder. Frequent urination is often seen in nervous persons, in diabetes, and in conditions where abnormal constituents cause irritation.

Incontinence or inability to hold the urine is due to loss of control of the sphincter muscle of the bladder. Retention of urine may exist with incontinence or with frequent urination, and so is likely to be overlooked. It is common in typhoid states, in hysteria, and in enlarged prostate, and is sometimes seen in demented patients. It is manifested by overdistension, and later by constant dribbling. Suppression of urine is the condition where urine is not secreted by the kidneys. If a catheter is passed and the bladder found empty when no urine has been voided in a reasonable time, suppression is easily differentiated from retention. Uremia may follow suppression, and death will not be long in coming if the condition persists.

The appearance of urine as to color — pale, light straw color, amber, dark amber, brown, reddish — should be described; whether it is clear, cloudy, opaque; whether it has its characteristic odor, or a strong ammoniacal odor, or is otherwise offensive; whether there appears to be mucus, pus, or blood in the sediment, and whether or not the voiding of urine is accompanied by pain; if so, where, and of what nature?

**Collecting Specimens for the Laboratory.** — In collecting and sending specimens to the laboratory, the nurse needs to be very exact in her methods, or the time of the physician is almost thrown away in studying specimens, and false conclusions may be arrived at. The name of the patient, the ward location, and the date on which the specimen is obtained should accompany each specimen. In all these procedures the receptacle must be absolutely clean, preferably sterilized, and so dried and cared for after sterilization that lint, dust, and bacteria are not allowed to collect upon it. It must also be tightly corked or otherwise protected, and promptly sent to the laboratory.

When sputum is sent, it should be as free from saliva as possible. It should be brought up by coughing or hawking. The best time for the collection of sputum is early in the morning, be-



fore food has been taken; where the patients will coöperate, it is well to have them rinse the mouth previous to collecting the specimen, to dispose of as much of the tissue waste as possible. A very small amount of sputum is sufficient. It is often difficult to obtain a specimen of sputum in the insane under any conditions, especially in tubercular cases. It is well for the nurse to obtain a specimen even under unfavorable conditions rather than to obtain none at all, but when she cannot observe the ideal methods, she should accompany the faulty specimen by a note of explanation sent to the laboratory.

In all new cases a specimen of urine should be sent to the laboratory as early as possible. A four-ounce specimen, collected the first thing in the morning, should be sent in all cases where it is not practicable to secure a twenty-four-hours' specimen. In female patients, be particular that discharges from the genital tract do not get mixed with the urine.

Do not send a specimen that purports to be a twenty-four-hours' specimen unless it is one. Any deviation from that fact should be so stated in a note accompanying the specimen.

In order to save a twenty-four-hours' specimen, begin, say at 7 A.M. Discard any urine now contained in the bladder at the hour you begin the observation, as this has been secreted by the kidneys some time before. After rejecting *this* specimen, save all urine passed from 7 A.M. on a given day till 7 A.M. the second day, and promptly send it to the laboratory. It will be seen how important is the conscientious coöperation between the day and night nurses, if these aids to diagnosis are to be relied upon.

You are confronted with many difficulties in making these observations upon the insane, owing to the carelessness and mischievousness of some, and the deluded states of others, but in a large number of cases, if you will take the pains to explain to the patient the reason for accuracy, you will find intelligent and often grateful interest shown, while in the unmanageable ones you will have to be continually on your guard to prevent them from thwarting your efforts.

To collect a specimen from a discharging sore, receive a few drops on a pledget of sterilized absorbent cotton, then place in a clean phial, cork tightly, and send to the laboratory.



In collecting specimens from the throat or pharynx, a swab made and fastened in the stopper of a glass test tube is used. This is previously sterilized. When ready to obtain the specimen, the stopper with the attached swab is removed from the tube, and the pharynx swabbed out, whereupon the swab is immediately returned to the tube and sent to the laboratory.

The male generative organs need to be observed for any unusual appearance of the parts—adherent prepuce, scars, sores, discharges, varicose veins, enlarged glands, hernia, and any swellings. The habit of masturbation is to be borne in mind, and patients of both sexes need to be observed closely in reference to it. The female generative organs should be observed for abnormalities in form, undue proportions, or atrophy of the external parts, vaginal discharges, sores, scars, eruptions, growths on or near the genitals, excoriations or growths near the urethra, rupture of the perineum, prolapsus of the vaginal walls or of the uterus, vermin, etc. If there is leucorrhea, its character, quantity, and time of appearance should be as accurately noted as possible. Absence of menses should be reported. Painful menstruation, or irregular or profuse menstruation, should be noted with as specific explanations as possible in regard to time, quantity, character of blood and accompanying symptoms.

The skin is to be observed as to cleanliness, coarseness or fineness, smoothness or roughness, presence or absence of scratch marks, vermin, eruptions, sores, scars, old or recent, and bruises. Is it hot or cold, dry, moist, or clammy? Note its color, as healthy, ruddy, tanned, pale, extreme pallor, sallow, cyanosis, flushing, jaundice, colored patches, or lines. Localized sweating and offensive sweating should be noted, also general sweating and its accompaniments.

The nurse needs to remember that pallor of the face may be due to anemia, to sudden loss of blood, to nausea, pain, faintness, or to strong emotions, as fear or anger. The face is red in fevers, in alcoholic conditions, in apoplexy and in excitement, as a rule. Circumscribed red spots are often due to vaso-motor disturbances, and show unstable emotional conditions. A hectic flush on the cheeks may be caused by phthisis, by septic conditions, and by excitement. The flush in pneumonia is

usually a deep red; it may be seen on one or both cheeks. A bluish look about the lips and mouth is due to imperfect oxygenation of blood. A yellowish skin may be the natural hue, or may be due to life in Southern climates, to jaundice, to cancer, or to the opium habit. Bright's disease often gives a peculiar waxy, white look; Addison's disease, a bronze shade to the skin. If there is swelling in any part, it is important to note if the skin pits on pressure.

In your observation on patients remember that it is not enough to make the original report. Be particular to note and report progress, deterioration, or a stationary condition, as regards physical conditions, behavior, habits, emotions, beliefs. No cases are as stationary as they seem to a casual observer. Do not hesitate to call the physician's attention to peculiarities frequently. With several hundred patients in his service, he cannot carry the details of each case in mind without your help.

## CHAPTER XII

### ACCIDENTS AND EMERGENCIES

THE nurse for the insane has to be prepared to meet the unexpected at every turn. Insane patients are liable to the same accidents and emergencies that befall the sane, and to many others in addition. Because of stupidity in deteriorated cases many accidents come about; because of mischievousness or malice, or of uncontrollable impulses, others result; false beliefs dominate certain patients, causing them to do violence to their fellows; sudden convulsive seizures subject their victims to accidents; self-injuries are inflicted, suicide is often attempted, and homicidal or at least dangerous assaults are by no means infrequent.

The best way to meet accidents and emergencies is to meet them more than halfway. Cross these bridges before you come to them; in other words, forestall them by foresight and supervision. A proper precaution prevents many unfortunate happenings. The nurse who keeps a watchful eye on her aged, feeble, and paralytic patients, guarding them against blows and falls, will prevent many a fracture and dislocation that would otherwise occur. Such patients easily topple over if jostled against, they slip on polished floors, stumble over rugs and small obstacles, often attempt feats they are unequal to, and are sometimes so annoying that they bring upon themselves the wrath of irascible ones. For such, eternal vigilance is required of their caretakers. Epileptics also call for constant supervision in order to keep them from falling, from scalding themselves, burning themselves by falling against radiators or grasping hot-water pipes, getting caught in machinery, or from sustaining other injuries. Certain ones require watching after convulsions, and between them, to prevent dangerous

attacks upon others. Contentious patients and those given to sudden impulsive outbursts are prevented from beginning their assaults much more easily than the results of their assaults are handled. The same thing is true of suicidal attempts. Let your supervision be so constant and so thorough that the chances for accidents and emergencies can rarely occur. When they do occur, immediately report the injuries received to the physician. If the injury requires the physician's attention, a written account of just what has occurred is the safest one to send, especially if he is at a distance, so that he may know just what appliances to bring with him. It is risky trusting to the verbal messages of frightened bystanders. Select as trusty a messenger as you can, and be explicit in either oral or written statements. In hospitals, your communications can usually be transmitted over the telephone. Be explicit as to the patient's name, ward location, and the nature of the accident.

In dealing with all emergencies, the main thing is to see clearly what to do, and to do it quickly but calmly. In order to cope with difficulties well, we must prepare ourselves beforehand by as thorough an understanding as possible of what are the right things to be done in the accidents and emergencies likely to present themselves. In all instances get rid of the useless bystanders if possible.

In a hospital with conveniences and plenty of help close at hand, and physicians within easy call, the resources of a nurse are not always taxed as severely as when she finds herself in private nursing or out in the world, with only her wits and her empty hands to meet the demands of the situation.

Emergencies in general have a way of coming up in the most inconvenient places and at the most inopportune times, taxing one's judgment and ingenuity to the utmost. At such times the nurse finds she must utilize whatever means are at hand, however incongruous they may seem, in place of the conveniences she is accustomed to be surrounded with.

The nurse is at all times supposed to set an example to others of calmness and self-control; she will be expected to "keep cool," and to know how and when to act, and when to refrain from acting, which is often quite as important as to act. It has

been said that if one has but three minutes in which to act, at least one minute should be used in thinking what course to adopt, then pursue it as calmly and directly as possible.

**Unconsciousness or Coma.** — Let us first consider unconsciousness or coma. This may be partial or complete. It may result from a variety of causes, and according to what has given rise to it the treatment must vary. Unconsciousness may accompany fainting or hysteria; it may be due to convulsions of various kinds, to apoplexy, intoxication, sunstroke, poisoning, shock, blows on the head, anemia, etc. In all cases of unconsciousness or semi-unconsciousness, be particular not to say anything in the patient's presence that it would not be desirable for him to hear.

**Fainting or Syncope.** — In fainting or syncope, the unconsciousness is due to some failure of the heart to send the blood to the surface of the body and to the brain. Consequently the head must be kept low to help overcome this difficulty. Mild attacks of fainting last only a few seconds, more severe ones last several minutes, or even longer. Of course, if the fainting is due to loss of blood, the main thing is to check the flow, but it may be due to a weak heart, to insufficient supply of air, to tight lacing, or to emotional or other shocks.

In cases of fainting, the person usually becomes pale and limp, and falls unless prevented. The pulse is very feeble, the breathing superficial and slow, the extremities cold, and he becomes momentarily insensible, or a greater degree of insensibility may supervene.

If you see a person getting pale suddenly, have him lie down immediately; this will often prevent swooning. If you can get to the person before he falls, help to lower him to the recumbent position on bed, lounge, floor, or ground, as the case may be. Do not put a pillow to the head. Loosen the clothing about the neck and waist, secure an abundance of fresh air, fanning him if need be. Do not crowd around or allow others to crowd around and shut off the air. Smelling salts, or ammonia, if handy, may be held to the nostrils, but be careful not to burn the nostrils, nor to cause the person to inhale too strong ammonia. The temples may be bathed with vinegar or brandy. If the patient fails to "come to," sprinkle cold



water on the face, apply hot bottles to the feet, and send for a physician.

**Epileptic Seizures.** — Just preceding a convulsion there may be a warning scream or cry. Not infrequently a patient has time to remove artificial teeth and to lie down before overtaken, but often he falls wherever he happens to be, and sometimes sustains severe injuries. The face may be pale at first, but usually becomes bluish, red, gray, or livid. The pupils are ordinarily dilated and the eyes turned upward. The breathing is usually irregular and often stertorous. The patient may froth at the mouth, and may bite the tongue in spite of your efforts to prevent it. The convulsive movements may be confined to the face or the arms, or sometimes the entire body shows contortions that are distressing to witness. There may be involuntary passage of urine and feces.

It does no good to fuss with epileptics to bring them to consciousness. The treatment consists in freeing them from liability of harm to themselves. When one falls in an epileptic fit, leave him where he falls, if no harm is likely to come to him there. Loosen the clothing as in syncope. Remove artificial teeth beforehand, if the patient gives warning enough, and place a rubber cork, or a folded towel, or a knotted handkerchief between his teeth to prevent him from biting his tongue. Wipe the froth and blood from the mouth, put a pillow under the head, and let the patient lie quietly and sleep if he will after the attack. If he shows any tendency to strike and bruise himself in his convulsive movements, it is well to restrain him enough to prevent this.

Sometimes epileptics are excited and dangerous after seizures, sometimes just dazed, but oftener they sleep heavily, and on waking have no recollection of the convulsion. They are of course to be screened from the sight of others if this can be arranged.

**Uremic Convulsions.** — Uremic convulsions are due to the failure of the kidneys to excrete waste matter from the body. The face is usually pale and often waxy looking, there may be swelling of the eyelids, face, and limbs, the breath may have a urinous odor, the pupils are usually dilated. The convulsions themselves are difficult to distinguish from those of epilepsy.

When they are clearly due to uremic poisoning, the treatment is to secure active purgation, and to produce sweating by hot packs or warm baths, thus calling to the aid of the disabled kidneys the excretory function of the skin. Have the patient drink copiously of water, and give an enema of normal salt solution.

**Hysterical Seizures.** — Hysterical seizures are sometimes difficult to distinguish from epilepsy. They occur most commonly in young girls or in neurotic women in early adult life, but no age is exempt, and even men of a certain type may be subject to hysterical seizures. A nurse should never use the term hysteria before a patient, and she needs to remember that hysteria by no means signifies shamming. Some hysterical attacks are under the control of the will of the patient, some are entirely beyond their control. Sometimes very grotesque and extraordinary conduct takes place.

In hysterical attacks the patient seldom falls where she would injure herself, never bites the tongue, often cries out repeatedly; the convulsive movements are of much longer duration than in epilepsy (an epileptic attack rarely lasts more than two minutes), the patient seldom entirely loses consciousness, she resists attempts to open her eyes, the eyes remain sensitive to touch, the pulse is usually normal, and the color of the face may be red or pale.

In general, treat a patient who falls in an hysterical attack much as you would one who faints. If you see that the pulse is good, and that the patient is made comfortable, and if you are convinced that it is hysteria that you are dealing with, it is well not to do too much, not to appear to notice the apparent efforts to elicit attention and sympathy, but quietly and calmly to say that you think the patient will soon be better. All onlookers should of course be dismissed at the outset. Loosen the clothing, giving free access of air. Sprinkling cold water upon the face may be tried. Sometimes pressure in the ovarian regions, or a sharp command, will cut short the attack.

Grave manifestations, and the attacks which especially simulate epilepsy, call for a physician. In a hospital, it is well to call a physician anyhow, whether the attack seems to you grave or the reverse.

**Apoplexy.** — Unconsciousness due to apoplexy is caused by rupture or the blocking up of a blood vessel in the brain. The patient usually gets dizzy, loses consciousness, and falls. The face is flushed, the pulse hard and rather slow, the breathing labored and often snoring in character (*stertorous*). The nostrils and one or both cheeks often puff out at each expiration, the eyes are partly closed and may be drawn to one side, the pupils are unequally contracted, the limbs relaxed, and one arm and leg, and the face often, show some evidence of half-sided paralysis (*hemiplegia*). Urine and feces may be passed involuntarily during the coma.

Place the patient in a horizontal position, with pillows under the head, and cover him lightly. Loosen the clothing. Keep him quiet; do not try to rouse him. Do not give stimulants. Ice or cold applications may be applied to the head and a hot-water bag to the feet. The physician should be summoned immediately.

**Sunstroke.** — Sunstroke is easily diagnosed because of the symptoms occurring in extremely hot weather and after undue exposure. It is ordinarily preceded by severe pain in the head. A similar condition may result from an improperly administered hot bath.

The bodily temperature sometimes rises to alarming degrees (105° to 112° F.), the face gets intensely red, the pupils become equally contracted, the pulse is full and bounding; later it gets weak, and stimulation may be necessary, but that is for the physician to decide.

The treatment is to move the patient to a cool, shaded place, remove all unnecessary clothing, apply ice or cold water to the head, and sponge the body with cold water till the temperature becomes reduced. Instead of sponging, cold water may be sprayed over the patient's body from a garden hose, or poured on the limbs and chest from dippers or pails. Do not pour it over the pit of the stomach. Later, wrap the person in a cold wet sheet, as in a cold pack. If the temperature rises again, resume the sponging, or other methods used, and the ice applications to the head. In a hospital the simplest way is to place the patient in a bath of about 70° F., and rub with ice until the temperature gets within the normal limits.

**Heat Exhaustion.** — Cases of heat exhaustion are those in which the exposure results in normal or subnormal temperatures instead of high temperatures, as in sunstroke. Such persons are treated as one would treat a case of shock.

**Shock.** — Unconsciousness due to shock requires prompt treatment. A reaction must be brought about speedily. Shock may follow a variety of conditions, such as fright or other strong emotions, operations, accidents, etc.

In cases of shock the patient is in a collapse; the pulse is weak and rapid; the temperature is subnormal, the skin cold and clammy; there is extreme pallor, as a rule, and a pinched, drawn look about nose and mouth; the breathing is feeble, often sighing in character; the eyes are dull; there may be partial or complete unconsciousness; nausea and vomiting may occur.

Put the patient in the recumbent position with the head lowered, loosen the clothing, apply hot-water bags or bottles to the feet, the arm pits, and the inside of the thighs, taking care not to burn or scald the patient. Put a mustard plaster over the region of the heart. Give hot black coffee, if the patient can swallow, or brandy or whisky in hot milk. Friction of the limbs toward the heart may also be tried. When reaction sets in after shock, as seen by improvement in pulse and color, stop the stimulants. High rectal or hypodermic injections may be ordered by the physician, or infusions of normal salt solution into the veins, or artificial respiration may need to be resorted to if the patient does not rally after the above-mentioned means have been tried.

**Blows and Falls on the Head.** — Unconsciousness due to blows or falls upon the head should be treated by placing the patient in a recumbent position with the head elevated, loosening the clothing, and securing quiet and darkness, letting the patient sleep as long as he can. It can do no harm to place cold applications to the head and hot ones to the feet. Hemorrhage resulting from the injury sustained must, of course, be checked, and the wounds dressed antiseptically.

**Asphyxia.** — Asphyxia is suspended animation due to failure of the blood to become oxygenated. This may come about from a variety of causes; but whatever the cause, it is imperative that

respiration be quickly reëstablished, or death will soon follow. The person must be treated on the spot. Delay is fatal.

**Artificial Respiration.** — Artificial respiration, then, is resorted to in all emergencies when the person has ceased to breathe. As already stated, it may be called for in shock, in asphyxia from ether or chloroform or other gases, in narcotic poisoning, in drowning, in strangulation, in the new-born infant, and in some other conditions. Sylvester's and Hall's methods are both to be studied.

**Strangulation from Hanging.** — Cut the body down, but do not let it fall. Pull the tongue well forward and clear the throat of mucus. See that artificial teeth are removed. Remove all constriction from the throat. Use Sylvester's method of artificial respiration.

**Asphyxia from Anesthetics and Poisonous Gases.** — In asphyxia from anesthetics or from poisonous gases, in addition to Sylvester's method, see that all the fresh air it is possible to supply is furnished to the patient.

**Care of Patient's Choking.** — This accident occasionally occurs among the insane, especially among cases of general paresis, or in an epileptic taken in a fit while food is in the mouth. Such patients should never be allowed to take food except under close supervision of the nurse, and very few paretics should be allowed to feed themselves even with a nurse close by, as they cannot be trusted to do it with safety. Sane persons are liable to have a fish bone or some food "go the wrong way" into the windpipe instead of into the esophagus, or if it does get into the esophagus, it sometimes gets lodged there in such a way as to press against the windpipe and cause distress and possibly alarming symptoms. Semi-unconscious patients may choke from the *vomit* getting into the air passage, and struggling patients who regurgitate their food during nasal feeding may have this accident happen to them. Patients may swallow their artificial teeth, or other foreign bodies may get so far back in the pharynx, or in the esophagus or the windpipe, as to cause choking. Many patients are too demented to show signs of distress, and the first intimation you have that anything is wrong is a chance observation of the livid face and the ineffectual efforts at breathing.



Removal of the obstruction is the first step toward relief. Whatever is in the mouth and throat can be hooked out by the fingers. The forefinger should then be crowded down the throat as far as possible to feel for other obstructions, if relief does not immediately follow. If some obstruction lodged in the esophagus is giving the trouble, it can sometimes be pushed farther down to where it is harmless by introducing the feeding tube.

A piece of bread swallowed may help to carry the troublesome object farther down the esophagus and into the stomach. Even if it is some indigestible substance that cannot be softened by the fluids in the stomach, no alarm need be felt. Give plenty of bread, potatoes, oatmeal, corn-meal pudding, and such foods as will have a tendency to incorporate it in the mass and carry it along without causing irritation to the alimentary tract. Do not give an emetic or a purgative under these conditions. If *glass has been swallowed*, get the patient to swallow cotton if you can, as this will help to engage the particles of glass in its fibers and so lessen the harm done. A diet similar to that outlined above will protect the mucous membranes of the stomach and intestines as much as anything can. Liquids should, of course, be prohibited for a time. On no account should an emetic or an enema be given. If a foreign body is lodged in the wind-pipe, its presence excites coughing, and this will often expel the intruder. A blow between the shoulders sometimes helps. A child may be taken by the feet and held head downward while smart blows are made between the shoulders. It is of no use to try artificial respiration, in cases of choking, until the foreign body is removed, and after that it is usually not necessary.

**Foreign Bodies in Other Passages.** — It sometimes happens that foreign bodies are introduced into the urethra, the vagina, or the rectum by insane patients, or a thermometer or catheter may get broken in these passages and slip beyond the control of the nurse. Such an accident should be reported at once to the physician. A rubber catheter that is old or in any danger of breaking should be discarded, and rectal temperatures should rarely be taken in the case of patients who would struggle so that such an accident could happen. Patients given to stowing away foreign bodies in the vagina need to be frequently ex-

amed, and the vagina cleansed daily with a mild antiseptic douche. Enemata should be given frequently to such patients as have the habit of crowding things in the rectum.

**Bruises or Contusions.** — A bruise or contusion is an injury received by direct violence to the soft parts which does not result in the breaking of the skin. The signs are pain and swelling and discoloration (*ecchymosis*) of the skin due to oozing of blood from the surrounding tissues and to its settling around the bruise. Hot applications immediately applied over a considerable surface surrounding the injury, or witch hazel, or alcohol and water, relieve pain and favor the absorption of the extravasated blood. Rubbing the ecchymosed spots with a bland ointment like lanolin helps the discoloration to disappear. Where great pain is experienced, cloths wet in hot water to which a little laudanum has been added, or a lead and opium lotion, may give considerable relief.

**Treatment of Wounds.** — In the treatment of most wounds the first thing to do is to cleanse them thoroughly from all dirt and clots with an antiseptic solution. The control of hemorrhage in a wound will be considered later. Superficial cuts of any extent usually require a few interrupted sutures; deeper ones may require hidden catgut sutures to draw the severed muscles together. Deep wounds may also need a drainage tube, or gauze, or a few strands of horsehair left in the bottom of the wound and so arranged as to protrude from the lower part. After being closed, the wound is then dressed antiseptically, and, as a rule, may be left undisturbed for several days. Silk or wire sutures require removal after a few days, but catgut sutures may be allowed to remain, as they become absorbed after a short time. Badly lacerated wounds need to have the ragged parts removed with a pair of scissors, and the crushed and torn parts placed in as natural a position as possible. Some lacerated wounds are treated by continuous irrigation. In cleansing all wounds, do not touch the wound itself, but squeeze or pour the antiseptic stream over them. Scalp wounds need to be cleansed thoroughly, and the hair surrounding them cut or shaved before the edges are brought together, and held by sutures or straps, or dressings, as the case may be. Have a care not to get the cut

hair into the wounds. Contusions of the scalp swell rapidly, often forming blood tumors (*hematoma*). In cut fingers, bring the edges close together, and bandage snugly. Sometimes, when a part of a finger or toe is entirely severed, if the parts be cleansed and immediately replaced in position and so bound up that firm and even pressure is made, there is still a chance of the severed member growing again. A thin layer of absorbent cotton held down by collodion makes a good dressing for slight wounds. Punctured wounds require careful cleansing; splinters or thorns must be removed, and the wound kept open so that it will heal from below. Some patients put needles under the skin, and some introduce them near the heart or lungs, where they are liable to cause death. Efforts at their extraction need to be made as soon as the injury is known about, as even when introduced into parts where their immediate presence could do little harm, they are a source of danger, owing to their tendency to travel to other and deeper parts of the body. The removal of a fish-hook or other barbed instrument should never be attempted through the hole at which it entered. It should be pushed all the way through and the head broken off. Insane patients sometimes bite their fellows or those who are caring for them. Severe, lacerated wounds may thus result. Such wounds should be squeezed gently under warm water to favor the flow of blood at first, and then thoroughly cleansed with antiseptics, as the saliva is likely to carry into the wound bacteria that would set up a troublesome inflammation.

**Insect Bites, Bee Stings.** — Insect bites, bee stings, and the like, are relieved by applications of soda, vinegar, ammonia, the tincture of ledum, listerine, or peroxide of hydrogen. The sting of a wasp or a bee should be removed from the wound by pressure or tweezers.

**Ivy Poisoning.** — The eruption caused by poison ivy is treated by applications of an alcoholic lead wash, hyposulphite of soda, grindelia, and other preparations, according to the advice of the physician.

**Burns and Scalds.** — Burns and scalds are injuries or destruction of the skin and soft parts due to the application of dry or moist heat. When due to dry heat, the injury is called a *burn*;

when to moist, a *scald*. They are essentially the same in effect, and require the same treatment. They are classified as burns or scalds of the first, second, and third degrees, according to the depth of the tissues injured. Burns and scalds are dangerous in proportion to the extent of the surface affected. Even a superficial burn may prove fatal through shock if a large part of the surface is involved. In young children, especially, a superficial burn affecting a third of the body is likely to prove fatal. Extensive burns, then, need, in addition to the treatment of the lesions themselves, treatment to prevent shock, or to counteract it, if it is already present. In cases of shock, guard against retention of urine by catheterizing if necessary.

The chief thing in treating burns and scalds is to exclude the air, as it is the contact of the air on the raw surfaces that causes the intense pain. In superficial burns, where the skin is not broken, cooking soda, cornstarch, or flour dusted thickly over the affected parts will help to allay the pain. The parts can then be covered with moist gauze, lint, or linen, and kept as quiet as possible. Or the skin may be protected by painting it over with the white of egg, or flexible collodion, or picric acid. If blisters have formed, or the epidermis is destroyed, the use of soda, flour, etc., is not to be thought of. Blisters should be pricked at their most dependent points with a clean needle, and the serum absorbed by gauze or cotton sponges, or by clean blotting paper. The skin should be kept in place as much as possible. The affected parts are then to be painted with picric acid if it is obtainable, or covered with liquid or oily applications, according to the conveniences you have at command, or, if in a hospital, to the most approved treatment there in vogue. Sometimes gutta percha tissue perforated in several places is laid over the burned surface, covered by absorbent cotton, and loosely bandaged. Gauze or lint saturated in solutions of soda, or of boric acid are often used, and when oil is applied, it is usually smeared on pieces of gauze, lint, or old linen, and then covered with cotton and bandaged. Carbolyzed vaseline, table oil, or carbolyzed sweet oil, oxide of zinc ointment, and the like, are the applications most commonly used. Carron oil (equal parts of limewater and linseed oil) is no longer recommended for burns,



although formerly much in vogue. For deep burns, continuous warm-water baths in which boric acid has been dissolved yield good results. In the treatment of burns, one needs to remember the great liability to deformity and the necessity for taking pains to prevent it as much as possible. In removing clothing, or later, dressing, from burned parts, never pull it away; cut with scissors as near as possible to the burned surface, and patiently soak the adherent material away by squeezing or pouring an antiseptic solution against the parts. Expose at one time only the part to be then dressed, finishing with each before beginning on others.

*Burns produced by strong acids* are first treated by bathing with some weak alkaline solution, as soda, chalk, ammonia, or even scrape the lime from the walls and use that to make a solution which will help to neutralize the effects of the acid. Or make a paste of common earth and apply if nothing better is at hand. Then treat the burn as you would one caused by heat.

*Burns caused by caustic alkalies*, such as potash, lime, ammonia, lye, should have applications of vinegar, lemon water, or very dilute nitric or sulphuric acids made to them to neutralize the effects of the alkali, before treating them as you would one caused by dry or moist heat. In powder burns, be particular to remove the particles of powder with a needle, otherwise permanent spotting of the skin will result. If carbolic acid gets spilled on the nurse or patient, immediately saturating the burned parts with alcohol will neutralize the effect of the carbolic acid.

**Clothing on Fire.** — If a person's clothing gets on fire, he should immediately lie down on the floor and roll over and over, keeping the mouth shut to avoid inhaling the flames. If he does not lie down, he should be thrown down, and a rug, shawl, coat, blanket, table cover, or some woolen or even cotton thing should be wrapped around him to shut out the air and stifle the flames. The doors and windows should be closed; on no account should the person rush to them, as the fresh air only makes the flames burn the fiercer. In all your efforts, fight the flames away from the face first. Pour cold water over the person if that is at hand.

If a fire occurs in the hospital, it is the nurse's duty to provide for the safety of her patients as well as her own. If it is in



some remote part of the institution, so that there is no danger of her charges being harmed, she should do as much as possible to prevent the spread of the alarm, and should seek to allay the fears and fright of those who become disturbed. If there is need of vacating the building, the able-bodied patients should be marshaled in the center of the hall facing the point of egress; every patient should be provided with a blanket; each room, closet, bathroom, pantry, or place where a frightened or demented person could skulk or hide away should be quickly but carefully searched to make sure that no person is concealed therein, and then the doors should be locked so as to prevent any one from going in the rooms later. When all is in readiness and the signal is given, the patients should be marched out of the hall, either by the door or the fire escape, as the situation demands, and they should be conducted to a place of safety, where some one is left in charge of them, in order that none may escape or come to harm in any way. Helpless patients need to be carried out in blankets to a place of safety.

If the fire drills are regularly and systematically carried out, the nurses and patients will be trained to do the right thing, so that when real danger threatens, if it ever does, there will be no confusion and hurly-burly. Nurses should school themselves to take the fire drills so seriously that every detail is attended to and insisted upon with almost the earnestness that there would be were there a real fire instead of a false alarm.

When fire is discovered in a building, of course the first thing to do is to try to put it out, and to sound the alarm. Closing all doors and windows not only helps to prevent the fire from spreading, but helps to keep the rooms from getting filled with smoke. In most cases it is better to wait for the firemen to come, rather than to pitch the furniture out of the windows, or allow it to be carried out where it may be stolen or injured by water or in other ways. It is sometimes well to remove certain articles from threatened rooms and carry them to places of safety, but in large cities the fire departments are so prompt and their means for handling property are so efficient that, as a rule, it is better to trust to their disciplined manner of dealing with these emergencies.

**Exposure to Severe Cold.** — Persons subjected to intense and long-continued cold may suffer merely from chilblains, from frost bites, or from grave exhaustion. In fact, chilblains and frost bites do not of necessity require long-continued exposure to produce them. Demented patients are subject to them on slight exposure. Chilblains are painful, they swell and become reddened, and are especially troublesome at night, or whenever the parts become much heated. To avoid chilblains, the parts should be warmly clad, and one should abstain from going directly to a hot stove or a register and suddenly warming the hands and feet when they are cold. When chilblains have actually formed, painting them with iodine every other day will relieve the itching, and bathing the affected parts every night and morning with tepid water, in which some nitric acid is dissolved (15 drops to a pint of water), or with cold water and ammonia, will afford some relief. If neglected, ulcers sometimes form, and will then need to be treated accordingly. Frost bites often take place without the sufferer knowing about them. As soon as noticed, the part should be rubbed with ice, or snow, or cold water should be applied, the object being to restore circulation to the part gradually so as not to cause sloughing. To this end the person should not be taken immediately into a warm room. As soon as friction and cold applications have resulted in the return of sensation and color to the part (it having been cold, pale, and often stiff before), the rubbing may be discontinued, but cold applications should be kept up for a time. If the effects of severe cold have resulted still more seriously, the person may be in a state of exhaustion bordering on coma, or may be quite comatose. He should be kept in a cool atmosphere, the clothing removed, and the body rubbed with ice or snow or cold water, later with pieces of flannel, furs, or the hand. The temperature must be gradually raised. He must not be allowed to yield to the drowsiness that is overtaking him; at the same time efforts must be made to conserve his strength as much as possible. Aromatic ammonia guardedly held at the nostrils will help to revive him, and nourishment, with or without stimulants, according to the severity of the case, should be given as soon as he can swallow. Beef tea, hot milk, black coffee, are

perhaps the best foods to administer. It may be necessary to give stimulants by the rectum, if the patient cannot swallow. As reaction begins to take place, the body may be protected by warm coverings, but the person should not be subjected to a heated atmosphere for some time.

**Hemorrhage.** — Hemorrhages may be external or internal. When external, they are easily detected, but when internal or when they occur in wounds much covered by dressings, they may only be discovered by the following constitutional symptoms: pallor, anxious face, dilated pupils, pinched nose, coldness of extremities, clammy skin, feeble, rapid pulse, shallow and sighing respiration, subnormal temperature, restlessness, perhaps thirst, dimness of vision, ringing in the ears, difficulty in speaking, later, unconsciousness and death, if the patient does not rally from the shock. Fainting has a tendency to check the hemorrhage, as the arrest to the flow of blood through the system affords an opportunity for the blood to coagulate, and so stop the mouths of the bleeding vessels.

Do not give stimulants in shock from hemorrhage unless so ordered by the physician, except when, in the absence of the physician, there is danger of heart failure.

Nature herself will often check hemorrhage in a short time. The veins, because of the character of their walls, and the absence of propelling force to the blood, quickly close, as a rule, and the clot that forms and plugs them arrests the hemorrhage. The arteries are more elastic than the veins; when they are cut, their muscular coats contract, lessening the caliber of the vessels, and drawing the arteries back into the tissues. This contraction and retraction help to form a clot which, if not too quickly dislodged, checks the hemorrhage. Exposing the injured ends of the artery to the air favors the formation of a clot, and elevation of the injured part, so as to reduce the force of the blood sent to it, also helps nature to arrest the hemorrhage. If these simple means fail, other artificial means must be tried.

**Artificial Means for Arresting Hemorrhage.** — The artificial means used to check hemorrhage are: (1) elevating the limb or part; (2) pressure directly on or above the bleeding vessel; (3) flexion of padded joint near the point of hemorrhage; (4) tying

(ligation) of the bleeding vessel; (5) application of heat or cold, or remedies to aid the coagulation of the blood (astringents or styptics); (6) cauterization; and (7) twisting or torsion of the bleeding vessel.

Elevation of a part should be tried with other means whenever practicable. Pressure on a bleeding artery must be made at the bleeding point or above the wound, or between the wound and the heart. If the bleeding vessel is too deep to be reached, plug the wound with a graduated compress, fastened firmly over the part. Bleeding can be easily controlled if the fingers can get to the artery and if the vessel is so situated that pressure can be made upon it against a bony surface. If the artery cannot be reached, pressure upon some of the branches leading to it will help to control the hemorrhage.

If a large artery has been severed, and medical aid is not at hand, it may be necessary for the one making pressure on the artery to be relieved by another, until a physician can be summoned; or a tourniquet may be improvised. Do not relax the pressure to see if bleeding has stopped.

To control bleeding in the *temporal artery* make pressure in front of the ear, just above the point where the lower jaw can be felt moving in the act of chewing. Severe hemorrhage in the head and upper part of the neck may be controlled by burying the thumb and fingers deeply in the neck just in front of the conspicuous muscle which runs diagonally across the side of the neck. Patients often sustain hemorrhages in the arteries at the wrist by thrusting their hands through window panes, often for the purpose of getting pieces of glass with which to cut their throats. Persistent bleeding in the *palm of the hand* is best checked by placing some hard substance in the palm (stone, apple, lemon), having the person grasp it tightly, then bandaging the closed hand, holding the arm high above the head. Hemorrhage in the *fore-arm* can be checked by placing a pad at the bend of the elbow, bending the arm and bandaging in that position. The *femoral artery* can be felt in the middle of the groin at the top of the thigh. Hemorrhages in the thighs and legs may be treated by a tourniquet, or by flexion of the hip and knee joints.

*Hemorrhage from a vein* is controlled by removing everything

between the wound and the heart that would retard the flow of blood (garters, etc.), by elevating the limb, and by applying a firm compress directly to the wound. If bleeding is due to varicose veins of the legs, apply a bandage over a compress, beginning at the toes and going up a short distance above the seat of bleeding. If bleeding is from the scalp, a compress and bandage will arrest it. Extensive cuts require sutures. Wounds of the face bleed freely, but are usually easily controlled by pressure or hot applications. Care should be taken to bring the wounded parts close together so as to prevent unsightly scars, and sutures are often necessary to this end. As has been said heretofore, it is important that all wounds should be treated, antiseptically, and one needs to remember, in the efforts to staunch the hemorrhage, not to touch the wounds with unclean hands, nor to let soiled materials come in contact with wounded surfaces.

**Cold and Hot Applications and Styptics.** — Cold applications are made in the form of pounded ice and ice compresses, and are often employed to check capillary hemorrhage. Extremely hot applications ( $125^{\circ}$  to  $130^{\circ}$  F.) have a stimulating as well as a styptic effect. (Warm water favors instead of checking hemorrhage.) Other styptics besides cold and heat are Monsel's solution of iron, perchloride of iron, alum, tannic acid, vinegar, and common salt.

Ligating or tying the ends of bleeding vessels, as well as torsion or twisting them, and cauterizing them, are means for arresting hemorrhage that are for the physician to apply.

**Cut Throat.** — Patients may make long cuts on the neck and do very little real injury, or they may make a small stabbing wound, injuring a large vessel, and may die almost instantly. They may cut the windpipe (trachea) instead of the vessels, and they may wound the epiglottis or the esophagus in their attempts to sever arteries. The windpipe can be felt in the front of the neck in the middle line. The large arteries and the veins of the neck are on each side of it, some superficially and some deeply located. If the windpipe has been cut, there is danger of suffocation from blood getting into it. Placing the patient on his side or face will help to prevent this. There is



also danger of pneumonia from much cold air gaining ready access to the lungs. Keeping light, moist, hot flannels over the wound helps to prevent this complication. The operations of tracheotomy or intubation may have to be performed in some of these injuries to the trachea. If the epiglottis or the esophagus is wounded, the food may have to be administered by rectum.

When any of the *large arteries of the neck* are severed, the hemorrhage is alarming, and will prove fatal unless instant relief is obtained. Firm pressure must be made upon the bleeding arteries between the wound and the heart, and maintained until a physician can be summoned and the ends of the vessels ligated. Have the patient sit with head bent forward and the chin pressed against the chest while pressure with the thumb and fingers is kept up on the injured vessel. Large veins like the jugulars should be compressed both above and below the wound for two reasons — to prevent bleeding from both ends, and to prevent the entrance of air which would cause sudden death.

Extreme care needs to be exercised in *suicidal cases* after wounds have been dressed, as such patients will usually watch their chance to remove dressings and reopen wounds. They will often feign sleep, will say how sorry they are that they tried anything so wicked, and will resort to all sorts of deceit to put the nurse off guard so that they may yet make a success of the thing in which they have been thwarted. Suicidal persons are very fertile in their plans for obtaining means and opportunity for self-injury. One desperate patient I have in mind had been thwarted in several attempts at self-destruction by the nurses getting to her as soon as they heard the crash of the broken window panes, before she could get time to cut her throat. Accordingly, she laid her next plan very carefully. Just before breaking a window pane she prepared the bare floor with soap-suds so that the nurses, on running to rescue her as they heard the broken glass, slipped, floundered, and some of them fell on the slippery floor, but luckily one succeeded in reaching her before the cut in the neck went deep enough to cause anything but a capillary hemorrhage.

*Hemorrhage from the Mouth* may be from the teeth, throat,

stomach, or lungs. If severe bleeding follows the extraction of a tooth, quickly replace the tooth if you can, or apply a compress, wet with a solution of alum, to the bleeding cavity.

*Hemorrhage from the Stomach (hematemesis)* consists of dark blood, often looking like coffee grounds, which is vomited up, usually mixed with particles of food, and often accompanied by distress in the stomach. It is usually followed by tarry stools.

*Hemorrhage from the Lungs (hemoptysis)* is bright red, frothy because of its admixture of air, is usually coughed up, is mixed sometimes with mucus, and is often accompanied by distress in breathing.

In any of these cases place the patient on the back, with head and shoulders elevated, give plenty of fresh air, let bits of ice dissolve on the tongue. In *hemoptysis*, equal parts of vinegar and water, or lemon juice and water, may be swallowed. Salt ( $\frac{1}{4}$  teaspoonful) was formerly recommended, but the danger of its causing vomiting makes its use of doubtful value. Place a light ice bag on the chest in hemorrhage from the lungs, and over the pit of the stomach when the blood comes from that organ. Do not allow the patient to speak, to move, or to swallow food, if the hemorrhage is from the lungs and is of considerable quantity. Do not give warm drinks in either of these conditions. Seek to allay anxiety by soothing words and an encouraging manner. Summon a physician at once. Hemoptysis, if alarming, may sometimes be arrested by cutting off the venous return from the limbs long enough to diminish the force of the blood, and so permit clots to form. This is done by placing temporary ligatures around one arm and the opposite thigh, and leaving them in place for about five minutes, then removing them and placing them on the corresponding limbs for the same length of time; this procedure may be repeated till hemorrhage ceases.

Hemorrhage from piles (*hemorrhoids*) may be checked by ice-water enemata, or pieces of ice placed in the rectum.

*Nosebleed (epistaxis)* is often profuse and difficult to check, but is rarely dangerous. It is usually preceded by a full feeling in the head, and some vertigo, and a congested face. The head should be kept upright, the chin elevated, the arm on the affected

side raised above the head, the clothing loosened about the neck. Pressure may be made near the nostrils, and cold applications to the forehead, the back of the neck, and the bridge of the nose. Avoid blowing the nose, as it disturbs the formation of clots. If these means fail to give relief, a nasal douche of ice water, or a strong salt solution (1 dram of salt to 4 ounces of water) may be used, or this solution may be sniffed into the nostrils, or in its stead equal parts of vinegar and cold water may be tried. *Plugging the nares* may need to be resorted to if the hemorrhage proves obstinate and exhausting.

In all cases of hemorrhage, the blood passed should be saved for the inspection of the physician.

**Treatment of Poisoning.** — The first thing to do in most cases of poisoning is to provoke vomiting. Do this by tickling the throat, or running the finger down the throat, or by giving an emetic. The *emetics* usually at hand in every house are warm water and salt (2 tablespoonfuls of salt to  $\frac{1}{2}$  pint of water), and mustard and water (1 tablespoonful of mustard to  $\frac{1}{2}$  pint of water). Other emetics are zinc sulphate (10 to 20 gr. in  $\frac{1}{2}$  glass of water), copper sulphate (2 to 5 gr.), tartar emetic (1 to 2 gr.), fluid extract of ipecac (15 to 20 minims), or a hypodermic injection of apomorphia ( $\frac{1}{30}$  to  $\frac{1}{8}$  gr.). If emetics fail to produce vomiting, use a stomach pump, unless an irritant or corrosive poison has been taken.

Save the *vomit* for the inspection of the physician, and note if the odor of any drug can be detected either in the breath or in the vomited matter. The urine should also be saved for analysis.

Send for a physician immediately on learning of the poisoning, but do not wait for his arrival before acting. Learn, if you can, what poison or poisons have been taken. A certain patient I have in mind was brought to the hospital suffering from poisoning, and it was afterward learned that she had that day and the day previous taken listerine, laudanum, valerian, ether, cologne, whisky, chloroform liniment, and Belladonna ointment; at least, she confessed, after resuscitation, to having taken these, and the symptoms which she showed led us to suspect that she had taken an overdose of opium also. If one can

determine positively what poison has been taken, the proper *antidote* (a medicine to counteract the effect of the poison) is to be administered, usually after vomiting has been produced. After vomiting takes place, it is well to cause the person to drink freely of milk, and in most cases it is wise to give an enema.

For *corrosive* and *irritant poisons*, emetics are, as a rule, best omitted. These poisons act so quickly on the tissues, causing severe distress and ulceration, that the most relief will be obtained by giving the chemical antidote to neutralize the effects of the poison, followed by soothing (*demulcent*) drinks to relieve the distress as much as possible. The *demulcents* are milk, white of egg, gum-arabic water, flaxseed tea, olive oil, gruel, boiled starch, etc.

For *narcotic poisoning*, besides emesis, antidotes, and treatment for stimulating the heart and for restoring the respiration, may need to be resorted to. Strong coffee, atropine, strychnine, whisky, are used as *heart stimulants*. In threatened paralysis of the respiratory movements, dash hot and cold water alternately on the chest, dilate the opening to the rectum, and try artificial respiration if necessary. Keep the patient awake, but do not exhaust him by walking him about. Striking the cheeks, the buttocks, and the soles of the feet vigorously will help to keep him awake.

When you are positive that an *acid poison* has been taken, give some alkali for an antidote — magnesia, cooking soda, lime-water, chalk and water, ammonia water ( $\frac{1}{2}$  teaspoonful to a glass of water), soapy water, even tooth powder quickly stirred in water.

When you know that a *strong alkali* has been taken, such as caustic potash or soda, ammonia, soft soap, an acid must be used as an antidote — vinegar and water, cider, lemon juice, or some of the other acids much diluted. Later, sweet oil may be given with soothing effect.

**Strangulated Hernia.** — A *hernia* is a protrusion of some internal organ or part from its natural cavity. Commonly speaking, by a hernia we mean some part of the intestine protruding through an opening in the abdominal walls. This is

also called a rupture. We speak of a hernia as *reducible* when its contents can be readily put back; when they cannot, as *irreducible*. A hernia is often supported artificially by an appliance called a *truss*. A hernia may become inflamed, obstructed, or strangulated. Strangulated hernia is a very serious condition. By this we mean that the hernia becomes constricted so that its circulation is cut off; it is then in danger of gangrene unless the constriction is relieved.

**Signs of Strangulated Hernia.** — The tumor becomes more tense, and tender; there is severe abdominal pain; the usual impulse in it noted on coughing is absent; vomiting of food, then of bile, and later of feces takes place; there is obstinate constipation, loss of strength, a rapid, feeble pulse, later, gangrene and collapse.

If the hernia cannot be replaced by manipulation (*taxis*), an operation (*herniotomy*) is necessary to save life.

**Fractures.** — The *signs of a fracture* are pain and tenderness, inability to move the part naturally, but unusual mobility when handled, deformity or displacement, crepitus, or a grating sound and sensation experienced by rubbing the broken ends together, swelling and ecchymosis. There is often inequality in the length of the sound and the injured limb.

**Management of Fracture.** — The nurse's duty concerning a fracture is to put the patient in as comfortable a position as possible and keep him quiet until the arrival of the physician. By injudicious handling or motion a simple fracture may be converted into a compound or a complicated one, as when the sharp end of a broken rib may be made to protrude through the skin or to pierce the lung. Violent patients may have to be held to keep them from thus injuring themselves.

If the clothing needs to be removed, take that from the sound side first, then rip or cut it away from the injured side, on no account subjecting the patient to the manipulations necessary to remove it in the ordinary way. If a foot, ankle, or leg be injured, it is important to remove the boot before swelling becomes extreme. Steady the injured limb as much as possible in removing the boot. If it cannot be removed easily, or if great pain is experienced, cut the boot at the seam. Remove



garters, unfasten suspenders, and in all work around the patient work quietly and with a view to sparing needless movement and pain.

**Moving an Injured Person.** — When necessary to move the patient to some distance, before the fracture can be reduced, *improvised splints* and an *improvised stretcher* have to be arranged. A man's overcoat buttoned, with the sleeves put inside, and long poles passed along the sides, does very well for a stretcher, or a blanket or a strong shawl rolled on poles will answer, or a broad fence board, or a window shutter from the nearest house. The point to be remembered is, in lifting the patient, lift him so that there is no unnecessary movement or jar, and have some one person assigned to lift and care for the injured limb after it has already been supported in as natural and as comfortable a position as possible by such splints as you are able to arrange.

For a *fractured clavicle* the patient should be placed flat on his back and a pad put in the armpit, the arm then bound to the side, the fore-arm placed diagonally across the chest. *Fractured fore-arms* should have splints placed on the back and front of the fore-arm from the elbow joint to the palm of the hand, and the arm carried in a broad handkerchief sling. The sleeve of a dress or of a man's coat, or the skirt of a coat, may be made to serve as a sling. If the arm is fractured, it should be bound tightly to the side of the chest. *Fractured ribs* require a broad body bandage applied tightly enough to prevent motion and to restrict deep breathing. There is danger of the broken ribs piercing the pleura or the lung. Spitting of blood is likely to follow this injury.

*Fractures of the skull* may render the person insensible. Vomiting, pallor, and feeble breathing may take place, or there may be confusion or unconsciousness. Bleeding from the mouth, nose, or ears may occur. Insuring darkness and absolute quiet, and immediately summoning the physician, are the chief things the nurse can do. Do not move the patient in such cases unless absolutely necessary. In cases where there is injury to the brain, due to fragments of bone pressing on the brain, an operation (*trephining*) for lifting these fragments may have to be

performed. Before this operation, that part of the scalp surrounding the injured portion requires shaving and antiseptic cleansing.

If an injured person is removed from the place of accident and placed in bed before the arrival of the physician, always bear in mind the necessity for as little movement as possible. Remove the clothing, and, as a rule, render the part as clean as you can, treating all wounds antiseptically if you possibly can. By attending to these matters, you avoid unnecessary delay, and the physician can then begin on the work that strictly belongs to him as soon as he reaches the bedside. If, however, a compound fracture exists, beyond efforts at checking hemorrhage, it is better not to interfere, but to let the physician direct the treatment from the start. In most cases of injury the clothing will need to be arranged so that the sound side may be compared with the injured one. In injuries to hip and thighs, place a towel over the genitals and lift the clothing to the waist line. The nurse needs to get in readiness, if they are obtainable, cotton and gauze bandages (3 to 6 inches wide), lint, absorbent cotton, adhesive plaster, plaster of Paris, some antiseptic solution (bichloride of mercury, 1 to 1000), plenty of hot water, towels, and sheets, and newspapers to protect the floor if plaster of Paris is used.

**Dislocations.** — The signs of dislocations are impairment of the ordinary motion of the joint, deformity, swelling, discoloration, and severe pain.

Dislocations are reduced by manipulation or by extension. Sometimes it is necessary to use a general anesthetic to overcome the muscular resistance before the parts can be put back in place. After the dislocation is reduced, the parts are held in place by firm bandaging until the strained or torn ligaments become strong again.

The nurse should summon aid as quickly as she can in these injuries, meanwhile maintaining hot applications to the injured parts.

**Treatment of Sprains.** — Hot applications, showering with hot water, or placing the part in hot water, the temperature of which is gradually elevated to the toleration point, and entire rest for

a week at least, with bandaging, are the most approved means of treatment for sprains. An opium and lead lotion often aids in reducing the swelling and tenderness. When these have subsided, passive motions and massage, if carefully applied, may be used. If the ankle is sprained, and the patient must be on his feet, strap the ankle with adhesive plaster, or use some other supporting dressing.

## CHAPTER XIII

### CARE OF SPECIAL MEDICAL CASES

THE insane are subject to infectious and contagious diseases and to general diseases as well as the sane. The care necessary to prevent the spread of contagion needs to be even greater than when nursing the sane.

Prompt and effectual isolation in infectious and contagious cases is imperative. The room should be stripped of all superfluous furniture, and those caring for the patient should avoid as much as possible mingling with others of the household. Utensils, dishes, bed and body linen used for the patient should be kept exclusively for him, unused portions of food should be burned, likewise withered flowers that have been in the room, and scrupulous attention to disinfection should be rigorously maintained. Thorough ventilation of the room is at all times important. The bare floors should be cleaned daily, avoiding the scattering of dust, and should be sprinkled with a disinfectant. The door should be kept closed, and outside of it should hang a wide sheet kept wet with a carbolic acid solution (1 to 40).

The bed and body linen needs to be soaked one hour in carbolic solution (1 to 40) or bichloride of mercury (1 to 1000) and wrapped in clean disinfectant sprinkled sheets before being sent to the laundry.

All discharges, sputum, vomited matter, urine, feces, blood, should be received in vessels containing some disinfectant; more is then to be poured on them, and the disinfectant thoroughly mixed with the excreta. The closed vessel should then be carried away and the mass allowed to stand, two hours for feces, and ten minutes for urine, before being emptied, burned, or buried.

Drains, sinks, water closets, and outdoor closets, should receive applications of chloride of lime several times daily. All dishes and utensils should be disinfected and boiled after contamination.

The patient's body should receive the strictest care as to cleanliness, and also certain parts should be immediately cleansed after the passage of excreta, and bathed in an antiseptic solution (1 to 5000 bichloride of mercury).

In the eruptive fevers the scales of skin may be prevented from falling about by smearing the skin with some antiseptic ointment. Secretions from the nose and throat may be received in soft rags or paper napkins, and immediately burned. The swabs used in cleansing the patient's mouth, and the rags used to cleanse the genitals and the anus, must be thoroughly disinfected and burned, and the nurse must thoroughly disinfect her hands each time after they have come in contact with any of the discharges from the patient.

The nurse should wear a cotton gown and should cover her gown completely, when temporarily mingling with others of the household, or when going out for exercise, with an outside wrap kept in an adjoining room. She should exercise especial care to disinfect her hands before partaking of food and should avoid taking the patient's breath, as well as unnecessary contact with the discharges. Especial attention must be given to her own health, as to food, sleep, and exercise.

When the patient is convalescent, the contaminated rooms must be thoroughly fumigated with sulphur or formaldehyde. The bedding and clothing may be disinfected by steam.

The nurse should thoroughly disinfect all her clothing that has been subject to contamination, and both patient and nurse should have a cleansing tub bath followed by a sponge bath of bichloride of mercury (1 to 3000), and entirely fresh clothing, before leaving the isolation quarters.

In death from infectious diseases, the body should be sponged with bichloride of mercury (1 to 1000), the nostrils, mouth, vagina, and rectum plugged with strong bichloride saturated cotton, the body wrapped in a sheet saturated with a strong disinfectant, placed in an air-tight casket, and given a speedy burial.



**Treatment of Fevers.** — The treatment of all fevers should be directed toward neutralizing the effects of the poison developed in the system by the action of the bacilli; toward promoting the elimination of waste products; toward reducing the temperature; and toward maintaining the nutrition. Stimulation may need to be resorted to, but only on advice of the physician. Medicines are of secondary importance; suitable food, in suitable quantities, and regularly administered, and treatment directed toward the conservation of the patient's strength, are the main reliance in fevers, and especially in typhoid. Enemata, possibly purgatives, generous supplies of drinking water, packs, and baths, are the means used to aid the excretory functions.

The room should be kept cool, from 60° to 70° F. Both too bright a room and darkness should be avoided. The night nurse should see that the night lamp is shaded on the side toward the patient. Too heavy bed coverings should be avoided. If abdominal tenderness appears, the clothing may be kept from weighing on the patient by using a bed cradle. Discard feather pillows in fever cases if you can secure hair pillows instead. Fresh linen needs to be supplied often, and the clothing and sheets must be kept dry, clean, smooth, and free from crumbs. Extra pains must be taken to guard against bed sores starting. This is all the more difficult, as it is important, if intestinal symptoms predominate, that the patient lie quietly on the back with as little exertion or movement as possible. When the physician gives permission, the patient's position in bed may be altered a little, and his back propped up with pillows or sand bags, and so relieve pressure upon the most dependent parts.

The diet must be liquid, such as milk, beef juices, egg water, koumys, or buttermilk, as ordered. Milk, either cold, warm, or boiled, is considered the safest and best diet as a rule. About two quarts should be taken daily, it being given regularly in six-ounce feedings every two hours. It is important that it be sipped slowly. If a patient is sleeping restfully, unless so ordered by the physician, do not waken him to give him his nourishment just on the hour, but exhausted cases in a stupor should be wakened, as they usually drop back again very quickly. Vichy

or limewater may be added to the milk, or a little coffee to flavor it, if permitted. The physician usually orders the milk peptonized, sterilized, or Pasteurized.

The drinking water should be boiled for fifteen minutes and then cooled by being packed in ice, but not by having ice put in it. Toast water and grape juice are grateful additions to the monotonous diet. Food should be given by means of feeding cups or glass tubes if possible.

Careful bedside charts should be kept by the nurse.

As a rule the liquid diet should be continued at least a week after the temperature has become normal. Later, soups, broths with rice, milk toast, meat jellies, soft eggs, junket, sago, well-cooked gruels, may be given, as allowed by the physician.

The appetite of a patient in the latter part of typhoid is usually voracious, and the nurse will have to be very watchful that no mischievous interference on the part of the friends, and no wheedling or connivance of the patient is allowed to endanger the patient's life in this respect. For indiscretions in diet are liable to produce hemorrhage and perforation of the intestines. Likewise exertion and movement, until sanctioned by the physician, should on no account be permitted by the nurse, however much the patient may urge the matter.

The mouth, teeth, and tongue should be frequently cleansed by swabbing with glycerine and lemon juice, boric acid solution, or listerine, especially after the patient has taken milk.

Daily movements of the bowels are as a rule secured by enemata. The bed pan is to be used until the physician gives express permission to use the commode. The anus and surrounding parts should be washed in an antiseptic solution after each stool. The presence of blood or of milk curds in the stools should be reported.

It may be necessary to cease giving nourishment if intestinal hemorrhage threatens. Ice coils are used in these cases. The patient may require stimulation. A transfusion of hot normal salt solution may be employed.

For distension of the abdomen, high saline enemata often give relief, or turpentine stupes or enemata.

If affusions, packs, cold sponging, or baths are prescribed, remember that each step must be so planned as to save the patient

every bit of unnecessary strain or exertion. If a tub bath is given, the patient must be lifted in and out of the tub. Sometimes as many as five or six baths a day are necessary to reduce the temperature, to quiet the delirium, to steady the heart, and to overcome the insomnia. Baths or some other hydiatric measure are usually ordered if the temperature goes above 103° F. Do not reduce the temperature below 100°, as there would then be danger of collapse.

Secure as much sleep to your patient as you can. Remember to guard delirious patients with extreme care, not relaxing surveillance for an instant.

**Cerebro-spinal Meningitis.** — The treatment of cerebro-spinal meningitis should aim to secure good nutrition, free bowels, thorough ventilation, darkness, and quiet. Noise, light, and even the lightest touch are likely to increase the spasms. Ice bags to the head and spine help to relieve the pain. Although the disease is not very communicable, the patient should be isolated.

**Influenza (La Grippe).** — In the treatment of influenza isolation is advisable. At the beginning a hot bath and hot lemonade are given to induce sweating, and such remedies as are prescribed by the physician. The patient should go to bed and stay there till the temperature is normal, and the conspicuous symptoms have disappeared. Carelessness in this respect often gives rise to a long train of troubles that may follow in the wake of this disease — catarrhal pneumonia, heart and kidney complications, neurasthenic symptoms. The strength should be maintained by liquid diet. Frequent hot baths give relief, in the nervous form especially. Ice bags to the head and spine relieve pain and insomnia. Antiseptic gargles should be used freely.

**Mumps.** — The treatment of mumps calls for isolation. Rest in bed during the acute symptoms is important. An abundance of fresh air should be continually supplied. Hot fomentations to the swollen and painful regions, liquid food, attention to the excretory functions, avoidance of draughts, and the use of antiseptic mouth washes and gargles, are the nursing measures especially to be adopted.

**Vaccination.** — Vaccination is usually performed on the outer side and upper part of the arm, or on the under side of the calf,

or on the front part of the thigh. The skin all around the part chosen should be thoroughly cleansed with soap and water, then washed with a solution of bichloride of mercury (1 to 5000), and rinsed with sterile water or alcohol. With a sterile needle a small square of the epidermis or scarf skin is slightly scratched, care being taken not to draw blood. The vaccine virus is then rubbed into the denuded surface with a sterile toothpick which usually comes with the vaccination outfit. The surface, after being allowed to dry, is covered with a light compress of sterile gauze.

If vaccination "takes," a papule appears on the third day which later becomes a vesicle surrounded by a red area. About the eighth day, pus forms, and the place gets very painful; then the inflammation subsides gradually, and about the twenty-first day the scab falls, leaving the characteristic white scar. Sometimes a rise in temperature, with headaches, nausea, and other constitutional symptoms may appear about the time that the vaccination is "working." In some cases, the lymph glands near by become enlarged, and the pain and swelling are quite severe. These inconveniences are, however, greatly to be preferred to the disease from which vaccination gives protection, or if not that, it greatly lessens its severity if smallpox does attack one.

**Measles.**—In the treatment of measles, isolation is of the utmost importance. Thorough ventilation must be maintained, and the room kept at about 65° F. The eyes must be protected from strong light. Cleansing of the eyes, nose, and throat, and the use of eye drops, gargles, and sprays are important points in the nursing, in addition to the usual fever nursing. The quarantine should be maintained for at least three weeks, and careful fumigation and disinfection secured after recovery.

**Diphtheria.**—The strictest isolation is imperative. Early administration of the diphtheria antitoxin is now considered the best and safest means of treatment. In most instances the administration of antitoxin is followed by a lessening of all the symptoms—the fever, the restlessness, the swelling, and the disappearance of the membrane. Antitoxin is injected in the thigh, or buttocks, or between the shoulders,

after cleansing the part with soap and water, scrubbing with an antiseptic solution, and rinsing with sterile water. The syringe and needle are sterilized and the serum slowly injected. Certain symptoms may follow the use of antitoxin — an eruption similar to scarlatina may appear, the joints may swell and become painful, and the temperature run very high. These effects are not dangerous, but often cause consternation. The nurse should receive an immunizing dose (100 to 500 units), and a full dose if the throat should begin to be sore. After four weeks' time, if still exposed to the contagion, the immunizing dose should be repeated.

The nursing is to be directed toward maintaining the patient's strength by diet, an abundance of fresh air, the avoidance of all unnecessary exertion, strict attention to the bowels and bladder, and to careful watching to guard against complications that may arise.

Guarding against taking the patient's breath or letting him cough in the face or on the clothing of the nurse are important precautions, and frequent spraying of the nurse's nose and throat as well as of the patient's is needful.

Distress in breathing is treated by inhalations of steam or medicated vapors, or, if necessary, by the operations of intubation, or of tracheotomy.

A patient should not be released from quarantine till all symptoms of the disease have disappeared and till repeated examinations have shown that there are no longer any diphtheria germs in the throat.

**Erysipelas.** — Quarantine the erysipelas patient and keep him in bed. Give plenty of water to drink, and light, nutritious diet. Follow the usual directions for fever nursing. If the inflammation has started from a wound, or if wounds or abrasions exist, they are to be treated antiseptically. Soothing applications to the inflamed areas are made according to the advice of the physician. The nurse needs to protect her hands by covering any scratches or abrasions that may be on them. She should never go from a case of erysipelas to take charge of a surgical or an obstetrical case.

**Dysentery.** — Absolute quiet in bed, milk diet, or arrowroot,



burnt flour and milk, egg albumen, beef juice, boiled water to drink, starch enemata, flushings of the colon, hot fomentations to the abdomen, ice to the anus to relieve straining — these are the chief things to remember in nursing cases of dysentery. The patient should of course use a bed pan, and the stools should be carefully disinfected. A flannel binder should be worn during the disease and for months after.

**Rheumatic Fever.** — Inflammatory rheumatism is another name for this painful disease; it is supposed to be of bacterial origin. The patient must be kept in bed. It is important to avoid draughts, and to keep the temperature from 68° to 70° F. Flannel nightgowns and undervests, and flannel sheets are to be preferred. The affected joints should be kept wrapped in cotton and should be put in a semiflexed position. The diet should be liquid, chiefly of milk. Water in abundance, lemonade, oatmeal and barley water are useful adjuncts. Pain is relieved by the application of ice bags (a flannel cloth intervening) or of hot water bags, or by various local applications that may be prescribed. All unnecessary movement and jarring must be prevented; the heart must be watched for signs of trouble, and the patient must not be allowed to exert himself or to get out of bed until the temperature has been normal for at least a week, and even then not without the permission of the physician.

**Pneumonia.** — The patient should be kept in bed with head and shoulders raised on pillows. An abundance of fresh air must be supplied night and day; the room should be kept at 70° F. Absolute quiet and as little talking as possible must be enjoined. Regular and sufficient nourishment, chiefly milk and raw eggs, is all-important. The food should be given by means of a glass rod or a feeding cup. After the crisis, semisolid food may be given, gradually increasing to regular diet. Stimulants are given, only on the advice of the physician. The bowels must be kept free by enemata if necessary. The sputum should be disinfected. Delirious patients must be constantly watched to prevent exertion likely to cause heart failure. Cotton jackets to the chest covered with oiled silk, poultices, antiphlogistine jackets, and other applications, are used accord-

ing to the advice of the physician. The patient should not be allowed out of bed till at least ten days after the crisis.

**Tuberculosis.** — Isolation of tubercular cases is of the utmost importance if there is cough and expectoration. It is best that the patient, if capable of coöperating, should know that he has the disease, so that he can be trained to safeguard others from the constant danger they would be in but for his care in regard to the sputum.

The sputum of phthisical persons contains bacilli in enormous numbers, and when dried, these germs mix with the dust, float in the air, and become a widespread source of danger. Tuberculous sputum must never be allowed to dry. It must either be received into rags or paper and immediately disinfected and burned, or into sputum cups containing a disinfectant that will kill the germs, or at least into cups containing water that will keep it moist until disinfection can be accomplished later. A 1 to 10. carbolic acid solution, or a 1 to 2000 bichloride of mercury, may be kept in the cups and cuspidores, except when accessible to suicidal patients. Receptacles should be emptied and cleaned frequently and boiled every twenty-four hours. If a fire is within easy reach, it is perhaps best to use paper in the sputum cups and burn the paper immediately after use.

The care of the tubercular patient may be summed up in a few words — the prevention of the spread of the disease, supplying an abundance of fresh air continuously, teaching the patient to breathe properly, furnishing sufficient quantities of nourishing and easily digested food, suitable clothing, bathing him frequently, and in securing moderate exercise in some cases and complete rest for others, and very little if any internal medication.

The nurse for the tubercular insane has to contend with extra difficulties, for in many cases she can get no coöperation on the part of the patient. Some patients will swallow their sputum, and others will expectorate wherever they wish — on the floor, bedding, behind radiators, in their handkerchiefs, or on their petticoats, in the faces of the attendants, and of other patients, and so on. Some will rub the expectorated matter in their hair or beards. Mischievous and suicidal patients have to be watched

to prevent them from drinking the disinfectants in the sputum cups. Male patients should be kept clean shaven. Unclean patients need frequent baths and shampoos, and their faces and hands washed many times a day. All scratches, cuts, abrasions, on either patients or nurses, should be treated antiseptically and kept covered till healed. The nurse should be particular not to stand in front of the patients when they are coughing or sneezing, as the minute particles of moisture expelled may contain multitudes of bacilli. The clothing and stools should be carefully disinfected.

Many patients who seem incorrigible at first as to the use of sputum cups, can, by patient training and encouragement, be persuaded to coöperate fairly well, and extra care on the part of the nurses must supplement this partial coöperation on the part of the patients. If the nurse keeps her own health up to par by hygienic living, and observes the rules for ventilation, and for the frequent disinfection of the ward, and the proper disposal of sputum, her duties in the tubercular wards are not attended with the dangers that exist on other wards where perhaps an unrecognized case may be endangering the entire ward.

The weight and appetite of each patient must be carefully watched; charts recording the temperature course, and that of the pulse and respiration, should be kept; the character of the cough and of the sputum noted; the frequency and severity of night sweats reported. Temperatures should be regularly taken morning and evening, the evening temperature not earlier than 5.30 P.M.

Patients who are able should spend as much time out of doors as possible, not walking about so as to exhaust themselves, but suitably clad, sitting or reclining in easy chairs, or lying on cots. Beds should be wheeled before open windows, or on balconies or verandas whenever practicable. With sufficient coverings and hot-water bottles, bricks, or soapstones, patients may be kept out of doors in very severe weather without danger or discomfort.

In cases where there is marked fever, the patient should be kept in bed so to conserve his strength as much as possible.

Patients capable of understanding instruction should be

taught deep breathing and encouraged to practice it in the open air or before open windows several times a day for ten or fifteen minutes at a time. Sponge baths should be given daily, and attention to the bowels and kidneys should be a routine matter. Patients having night sweats should be given a glass of hot milk at about 4 A.M. regularly, and should be dried with hot towels and put in dry clothing at the termination of the sweats.

If there is distress in breathing, inhalations of moist air often afford relief, or hanging moist towels before a hot-air register helps a little. The temperature of the room should be kept from 70° to 75° F. as a rule.

If cod liver oil or emulsions are administered, they should be given in small doses at first and gradually increased as the patient can tolerate them.

Tubercular patients should receive small quantities of easily digested food often and regularly.

**Tonsilitis.** — Hot-water applications or poultices give relief in the suppurative form and hot-water gargles help also. Iced compresses and ice bags are used in the follicular form of tonsilitis; also applications of bicarbonate of soda applied by the finger to the tonsils. When the abscess is opened, or if it bursts, the patient should be instructed, if awake, not to swallow the contents. Antiseptic gargles should be used after the rupture of the abscess. Liquid nourishment is called for until the swelling and soreness subside. Ice cream is a welcome addition to the diet. Bits of ice are given in the early stages, and inhalation of steam if breathing is difficult.

**Enteritis.** — The treatment consists in securing fasting in the acute conditions, later, in administering the proper diet, in maintaining rest in bed, and in flushing the intestines after stools. Flannel binders should be worn in chronic cases, and the patients need to avoid getting damp or chilled. Careful inspection and reporting of the stools, and their disinfection, are important in the nursing of either acute or chronic cases.

**Appendicitis.** — The treatment for appendicitis is both medical and surgical—absolute rest, liquid diet, and ice bags to relieve pain. If an abscess is discovered, or if the symptoms persist for three days, an operation for the removal of the ap-

pendix is usually advisable. The nursing then is similar to that after any abdominal operation.

**Intestinal Obstruction.** — The treatment varies according to the cause of the obstruction. Lavage of the stomach may be called for to relieve the distension and the intestinal movement. Thorough enemata are usually given under the direction of the physician, sometimes under an anesthetic. In giving an enema the nurse should note if the tube meets obstruction, and at what point; whether the fluid is returned immediately or is long retained; whether it is colored by fecal matter, and what the character is of that which comes away. She needs to remember that in fecal impaction, causing nearly complete intestinal obstruction, there is often diarrhea, the loose stool tunneling its way past the hard fecal masses. Vomiting and hiccough are relieved to some extent by cracked ice. Turpentine stupes are sometimes ordered for distension. Surgical interference may be called for.

**Bronchitis.** — Rest in bed with head and shoulders elevated, liquid diet, free action of bowels and kidneys, abundance of fresh air, inhalations of medicated vapor, hot fomentations to the chest, hot drinks, and hot foot baths are the nursing measures for cases of bronchitis.

**Asthma.** — One with this disease needs an abundance of fresh air; the patient should be allowed to assume the position that affords the greatest relief; hot foot baths, hot drinks, especially coffee, hot poultices over the chest, honey during the attack, whiffs of chloroform, inhalations of nitrite of amyl, or of burning niter paper, or of other drugs, pastilles, and cigarettes, are among the means of relief that are tried for these sufferers.

**Pleurisy.** — The treatment is rest in bed and rest of the affected side as much as possible. Talking should be avoided. Lying on the painful side and strapping that side with adhesive straps help in diminishing movement. There should be an abundance of fresh air, and light, nourishing diet. Ice bags afford some relief to pain. Where the effusion is abundant, restricting the amount of liquid food, using purgatives, and stimulating the skin and kidneys to freer action, are believed by some to be of material benefit.



**Endocarditis.** — The treatment is rest in bed and nourishing diet. Rest during the primary disease is probably as much of a preventive measure as we have at command. The diseases that give rise to this condition are chiefly rheumatic fever, tonsilitis, pneumonia, and scarlet fever. Often the first intimation that the patient has developed this lesion of the heart is when the physician discovers a soft blowing murmur there during the course of some of the acute diseases. Persons with these valvular lesions can with care live many years and suffer only from time to time from the effects of the defective valves. When the heart fails to compensate properly toward the end of their lives, dropsy, congestion of the lungs, and extreme difficulty in breathing are the symptoms to be expected.

**Chronic Valvular Lesions of the Heart.** — The treatment is to relieve the dropsy by medicines, or, if necessary, by puncturing the edematous legs and bandaging them with Canton flannel bandages. The distress in breathing is alleviated to some extent by suitably arranged head rests, as the patient is obliged to rest and even to sleep in the sitting posture. Have a care that the head rest is broad enough to support the head when it falls over on the side. Tapping the chest may be necessary. Antiseptic cleansing of the skin should precede this, as well as all operations for dropsy. An ice bag over the region of the heart sometimes lessens the palpitation. The diet must be so regulated as to prohibit starchy foods and all others that would cause flatulence. Vomiting is allayed by bits of ice in the mouth, effervescing drinks, and a mustard plaster over the heart. The sleeplessness, starting in sleep, and frightful dreams can be helped by remedies, and also by the soothing offices of the nurse. The bowels and kidneys need to be kept free. It is often necessary to diminish the quantity of liquids taken; four ounces at a time is sufficient allowance when nausea and distaste for food are marked. Stimulants are given only when prescribed by the physician.

The treatment for *Palpitation of the Heart* is to be directed toward quieting the emotional excitement which gives rise to this symptom in so many nervous persons. Digestive disturbances, excessive use of tobacco, and other stimulants are often

at the bottom of this condition. It may also be the result of organic troubles of the heart. Whatever the cause, seek to allay the apprehension. Moderate exercise often gives marked relief in some cases, others require rest in bed. Hot baths should be avoided, but tepid baths and cold sponging are beneficial. Regulation of the diet and sleep are all-important. Starchy foods and heavy evening meals are to be prohibited.

The treatment of *Angina Pectoris* is to so regulate the patient's life as to avoid all unnecessary strain, indigestible food, and meals at late hours. During the paroxysms, the inhalations of amyl nitrite or a few whiffs of chloroform give relief.

**Uremia and Chronic Bright's Disease.**—The treatment of *Uremia* and of *Chronic Bright's Disease* may be considered together. Saline purgatives, copious draughts of water, and warm baths are the chief means used to favor the action of the kidneys. Inhalations of chloroform are given during convulsions.

Persons with chronic Bright's disease should regulate their lives so as to throw the least possible strain upon the heart, arteries, and kidneys. Moderate exercise, freedom from worry, regular bowels, active skin and kidneys, copious water drinking, as a rule, total abstinence in regard to alcohol, light and nourishing diet, but little meat, and plenty of milk, are the means to be used to this end. If the heart is seriously affected also, the patient should drink water in small quantities.

**Diabetes.**—The treatment is to restrict the diet as to starchy foods and those containing much sugar. The diabetic patient should lead a quiet life, free from strain and worry. It is necessary to keep the skin active by daily tepid or cool bathing, and the bowels free, and to avoid getting chilled. A troublesome itching that is common in this condition is relieved by lotions of hyposulphite of soda, or by ichthyol and lanolin ointment. The thirst for water may be indulged, and milk, buttermilk, tea, coffee, cocoa, lemonade, and fruit juices sweetened with saccharine tablets, are allowed. Only food easy of digestion should be taken. Bread made from gluten flour, or almond or cocoanut biscuits should be substituted for all other kinds of bread. Sugar and syrups are prohibited. The patient may take clear soups, fish, sea food, meats (except liver), lettuce,

celery, tomatoes, spinach, asparagus, cucumbers, pickles, and most fruits. Articles especially to be avoided are thick soups, ordinary breadstuffs, hominy, rice, tapioca, macaroni, potatoes, turnips, cabbage, parsnips, squashes, beets, beans, peas, corn, beers, and wines.

## CHAPTER XIV

### SOME POINTS IN SURGICAL NURSING OF THE INSANE

IN discussing briefly some points in surgical nursing, more particularly of the insane, I shall presuppose that the nurse already understands something of the germ theory of certain diseases, that she realizes that we are surrounded with minute vegetable organisms invisible to the naked eye, and that it is because of these bacteria that we adopt the modern methods of antiseptic surgery. Bacteria are in the air, the water, the soil, our food, and our bodies. Some bacteria cause disease, others fermentation, still others putrefaction. Bacteria multiply rapidly under the conditions of moisture and a suitable temperature ( $85^{\circ}$  to  $104^{\circ}$  F.). A temperature below  $65^{\circ}$  F. retards the growth, but even freezing does not destroy them. Most bacteria are killed if subjected for two or three minutes to a temperature above  $160^{\circ}$  F., but some require  $284^{\circ}$  F., and three hours' exposure. Some bacteria are destroyed by sunlight. All bacteria are not disease-producing. Some have important duties to perform in the body. Germs are embedded in our skins so firmly that long-continued and vigorous scrubbing and the use of disinfectants are necessary procedures before undertaking surgical operations. We cannot hope to get all of them off by scrubbing, and so we use disinfectants to kill the germs, or antiseptics to render them as harmless as possible. Our mouths are full of germs. The very germ that is responsible for the infection of pneumonia is believed to be habitually present in the mouth of almost every healthy person. It is only when these organisms gain entrance to the lungs, and the person is not strong enough to resist their destructive work there, that pneumonia develops.

The disease-producing bacteria enter the body through abra-

sions in the skin and mucous membranes, through the alimentary and respiratory tracts, and through wounds. The pregnant woman may infect the fetus through the placenta. Through the activity of bacteria, certain poisons called *toxins* are developed in the body, and it depends upon the power of the body to resist these poisons whether the disease shall conquer the patient or the patient conquer the disease. Bacteria leave the body through the skin, lungs, kidneys, or bowels. Hence the necessity for using disinfectants and antiseptics in scarlet fever when the skin is peeling, and in smallpox when the crusts are drying, in pneumonia and phthisis to disinfect the sputum, and in typhoid fever to render innocuous the urine and the stools.

The *chief disinfecting agents* are heat and chemicals. When we use heat, the process is spoken of as *sterilization*; when chemical agents are used, as *disinfection*. Heat, and especially fire, is by far the most thorough means at command for disposing of infected articles, such as playthings, books, and furnishings that have been contaminated, and also of sputum and feces. In surgical work, fire is not generally used to sterilize instruments, as it destroys their temper, but heat in the form of hot air, moist air (steam), and boiling water, is one of our most reliable germicidal aids.

Hot air or baking should continue one hour at a temperature of 300° F. Boiling water (212° F.) destroys germs in from two to four minutes. Sterilization by steam is the accepted means for clothing, blankets, carpets, curtains, mattresses, pillows, towels, dressings, instruments, and so on. Moist heat at 140° F. for ten minutes will destroy most of the disease-producing germs.

The most commonly used *chemical disinfectants* are bichloride of mercury (corrosive sublimate), carbolic acid, and other coal-tar products, such as creolin, and lysol, formaldehyde, permanganate of potash, hydrogen peroxide, boric acid, iodoform, aristol, alcohol, chlorinated lime and sodium carbonate combined, ichthyol, sterilized vinegar, bicarbonate of soda.

*Normal salt solution* is much employed in aseptic surgery as preferable to sterilized water, specially for irrigation, for injections in case of shock, in diabetic and uremic coma, in hemorrhage, in gynecology, and the like. It is so called because it



resembles so closely the degree of alkalinity of the blood. It is made by dissolving prepared tablets in one quart of sterile water, or roughly, one teaspoonful of salt to one pint of water. When hypodermic injections of the saline solution are used, they are made on the chest, abdomen, between the shoulders, or on the arm or thigh. From a pint to two quarts of the solution at a temperature of 100° F. are injected. The skin should be sterilized and all the appliances used.

**Bandaging.** — Bandages are strips of fabrics — gauze, flannel, muslin, rubber — used to keep dressings and applications in place, to make compression, to support and protect parts, and to prevent motion. The first requisite concerning a bandage is that it shall fulfill the especial purposes for which it is applied; next, that it shall be comfortable; and lastly, that it shall be without wrinkles and look well. Excessive tightness must be avoided; on the other hand, one must remember the tendency of bandages to become loosened after being worn awhile, and so must apply them snugly and with even pressure. In bandaging the extremities, the fingers and toes are to be left uncovered, so as to watch the circulation in these parts. If they are cold, numb, swollen, or livid, the bandage should be loosened.

In applying a bandage, fix it by two or three overlapping turns around a part, holding the outer surface of the roller next the skin. Bandage from below upwards and from within outwards, over the front of the limb. Use firm, even pressure throughout. Let each succeeding turn overlap two thirds of the preceding one. Keep the margins parallel, and let the crossings and reverses be in line and on the outer side of the limb. Do not make reverses over bony prominences. Fasten the end of the bandage by a safety pin or a stitch or two, or by tearing the ends in two strips for a little way, reversing and tying about the part. In removing a bandage, roll it loosely in the hand as it is unwound, so as to keep it all together in your hand.

**Surgical Technique.** — The surgical nurse needs to acquaint herself with the accepted methods of preparing the operating room, the dressings, sutures, and instruments, and all other appliances. She needs to know how to prepare the patient for

the various operations, how to assist at each operation in whatever capacity assigned her, and how to care for the patient properly after operations through to convalescence. She needs to acquaint herself with the various steps of the operations at which she is likely to be called upon to assist; to be thoroughly familiar with the names and uses of the various instruments; and to know what ones are likely to be called for at a given operation, and the order in which they are to be handed. These necessary instructions are to be learned from books and lectures, and from practical instruction in the operating room.

The *anesthetics* in most common use are nitrous oxide, ether, chloroform, ethyl bromide, and ethyl chloride.

**Preparation for General Anesthesia.** — A patient should be allowed no solid food for twelve hours previous to taking the anesthetic; beef tea, coffee, or tea may be given up to within four hours of the operation, after that nothing but water. Insane patients need to be watched with great care in this respect, as some will often steal or get other patients to steal food for them unless prevented. This abstinence concerning food is to prevent vomiting during the inhalation of the anesthetic — an undesirable happening for several reasons; the vomiting of solid food may endanger the patient's life, solid particles getting into the trachea or getting lodged in the throat so that suffocation might result; or a pneumonia may follow as a secondary result; furthermore, vomiting delays the operation and renders the operator's task unnecessarily difficult, and it may come at a stage in the operation when delay would be especially unfortunate. In emergency cases, if a person has to be anesthetized soon after a meal, it is often desirable to wash out the stomach before administering the anesthetic.

The bowels must be evacuated by enemata persisted in until you get a clear return, or by cathartics, if ordered; the bladder by urination, or, if necessary, by catheterization. The patient should be instructed to urinate just before going to the anesthetizing room, even if he urinated shortly before that time.

Sometimes the physician orders whisky or brandy by the mouth, or a hypodermic injection of morphia one half hour before the administration of the anesthetic.

The clothing should be clean, light, and warm, and free from constrictions about throat, waist, or elsewhere. The physician will examine the urine and the heart before deciding upon giving an anesthetic.

Just previous to the administration of any anesthetic, the mouth must be thoroughly examined for artificial teeth, tobacco, or any foreign substance that may be stowed away in the mouth. The word of a patient must not be taken in this respect. Some persons will deny having false teeth, and some are too dull or too stupid to tell the truth; sometimes there are only a few false teeth, perhaps only one, and not realizing why the question is asked, the patient will deny having any. On no account must this duty of examining the mouth be neglected, as the teeth or other foreign objects are likely to be swallowed, or to cause strangling, when unconsciousness supervenes.

The patient should be anesthetized in a room apart from the operating room, so as to be spared every possible sight and thought of the ordeal to which he is to be subjected. He should be spared the sight of the surgeon and his assistants in operating gowns, and the sound of the rattling of instruments. A few cheerful reassuring words by the nurse and the physician will help to soothe the very natural excitement and apprehension attendant upon the operation. Beyond this talk and the necessary directions of the physician, strict silence should be maintained. The reprehensible practice of some physicians and nurses of chatting during the administration of an anesthetic cannot be too strongly condemned. It is an affair of grave moment to the patient, unless he is too demented to understand about it; physicians and nurses should imagine themselves in the place of the one on the table long enough to reflect how they would feel to be lying there helpless, and trusting their very lives to persons who are perhaps chatting about some festivities of the night before, or what operations are on for the next day, or what will be done in these operations to-day in case such and such conditions are met with. Or even if the talk is quiet and dignified and unobjectionable in itself, it should still not be allowed unless really necessary, as it increases the time necessary to get the patient under the anes-

thetic. It must be remembered, too, that patients can often hear what is being said when they are unable to make any sign.

The *means for resuscitation*, and the things likely to be needed from start to finish, should be close at hand upon a small stand at the head of the anesthetizing table, and within easy reach of the anesthetist — ether, chloroform, an ether cone, a chloroform mask, a chloroform dropper, vaseline or oil to anoint the face around the nose and mouth, a sponge holder, a tongue forceps, a mouth wedge and gag, anesthetizing stethoscope, gauze or cotton swabs, a pus basin, two hypodermic syringes in working order, one charged with  $\frac{1}{30}$  gr. of strychnine, a tumbler of sterile water, 2 oz. of vinegar, 2 oz. alcohol (95%), 4 oz. whisky or brandy (ammonia, digitalis, atropine, and amyl nitrite are usually provided also), several towels, and perhaps an electric battery, and an oxygen inhaling apparatus.

For most operations the patient should lie on the back, with the head on a level with the body or on a small, flat pillow. The body is warmly covered with blankets, and the arms are so arranged on the chest that the radial pulse may be easily felt. A towel should be spread under the chin.

On rare occasions it falls to the lot of the nurse to give the anesthetic, but as a rule her duties in the anesthetizing room are confined to watching the patient, to restraining him if struggling takes place, to holding the hand and calming nervous patients, to watching the pulse, to managing the head, towels, and basin, if vomiting occurs, and freeing the mouth and throat from food and mucus, to rendering any help she can to the anesthetist, to crossing the arms and pinning the sleeves to the nightgown before moving the patient to the operating table, and to watching the patient carefully until the return of consciousness. She should not restrain slight restless movements, but must be alert to help when help is necessary. It is the nurse's duty during the operation to see that the position of the arms and legs is unconstrained, and also when coming out from anesthesia. The arms must not be allowed to hang for even the short time of transference from anesthetizing table to operating table, and the patient's body should be kept in a horizontal position in making the transfer.

If at any time during the administration of an anesthetic respiration shows signs of being suspended, and speaking to the patient or pressing upon the chest does not serve to establish breathing, the foot end of the table will need to be elevated; these means failing, the tongue must be pulled forward, the jaws lifted, the mouth gag inserted, and perhaps heart stimulants, Sylvester's method of artificial respiration, and the Faradic battery called into use.

If vomiting occurs at any time, the mask must be removed, the head turned to one side, and on a level below the body, to prevent the entrance of the *vomit* into the air passages. The mouth should be cleared of food and mucus before replacing the mask. If there seems to be an accumulation of much mucus in the pharynx, this must be removed by swabbing out the throat with a sponge firmly fastened in a pair of long forceps.

The *danger signals during anesthesia* are dilated pupils, irregular or arrested breathing, blueness of lips and face, swelling of veins in forehead and temples, and at first a slow, later a rapid, almost imperceptible pulse.

*Patients coming out from ether or chloroform* must not be left alone an instant. They are usually transferred to their beds while partly unconscious, the clean bed being previously warmed by hot bottles, which are later to be placed at the patient's feet, under the arms, and between the thighs, if the operation has been prolonged and attended with any sign of shock.

The placing of gauze wet in vinegar over mouth and nose, after wiping away the vaseline, and before the patient is removed from the operating table, is a favorite procedure with some who think that it lessens nausea and retching. Cold compresses to the throat help to control vomiting. After abdominal operations, during retching and vomiting, the abdomen should be supported by the nurse.

Remember that patients often hear what is said when they are coming out from an anesthetic while they appear to be still unconscious. Neither the operation nor their condition should be discussed in their presence. When only half conscious from the anesthetic, patients sometimes need to be urged to "spit out," if they do not seem inclined to expel the *vomit* that comes up in the mouth.



Nourishment is not allowed for twelve hours as a rule. Physicians differ greatly in what they will allow after anesthetics, especially after certain operations. Some allow sips of plain hot water, or hot soda water, others pellets of ice, others black coffee, or strong tea, and others will not allow even a sip of water for many hours (36 to 48 hours), especially after abdominal operations. Some will allow the patient to rinse the mouth frequently and spew out the rinsings. None will object to frequent moistening of the lips and tongue with ice wrapped in gauze, to relieve the distressing dryness of the tongue. Be careful to touch the fore part of the tongue only, or you will be likely to nauseate the patient. Patients get desperate when thirst after anesthetics is extreme; some, unless watched, will try to drink the water from the hot-water bottles, or will attempt to get out of bed and get at that in the toilet pitcher. One pint of saline solution given slowly as a rectal douche, helps to relieve intense thirst.

The room of the patient should be kept about 70° F., and an abundance of fresh air continuously supplied. The bed should be accessible from both sides, the eyes shielded from light, and yet the face in sufficiently strong light that pallor or other signs of hemorrhage may be detected. A basin should be close at hand but out of the patient's sight except when in use.

Patients often complain of severe backache after operations. Rubbing the back affords relief in some cases; in others, placing a small pillow under the back, or, if the nature of the case will admit of it, turning the patient partly on the side and supporting the back with pillows, will be successful. Abdominal pain may be due to the operation, to gas in the abdomen, to too tight binders, or to a distended bladder. Heat is acceptable when pain is due to manipulations of the abdominal organs; abdominal tension is relieved by a roller placed under the knees; the escape of gas may in some cases be helped by turpentine stupes, or by the insertion of the long rectal tube; a distended bladder should be evacuated, and uncomfortable dressings made comfortable, if possible, by nicking them, if too tight, or possibly by reapplying, but only on permission of the surgeon. Nervous patients, alcoholic cases, and drug habitués often show considerable

nervous excitement and restlessness which can sometimes be alleviated by massage; others are greatly helped by a little judicious sympathy and assurance. Headache is often relieved by cold compresses or an ice bag applied to the head.

Insane patients need especial supervision in coming out from an anesthetic, and after certain operations, until healing takes place, to guard against any chance removal of dressings or disturbance and contamination of them, or any exertion that would be prejudicial to the patient. Vigilance must be exercised at every hour of day and night in certain cases. It is sometimes necessary to apply a camisole or a safety sheet to prevent self-injury, or struggling, or other exertion that would be harmful. The quantity of urine should be noted and reported after etherization, because of the prejudicial effects of ether on the kidneys in some patients.

The *local anesthetics* most commonly in use are cocaine, eucaine ethyl chloride, alcohol, ether, crushed ice, or crushed ice mixed with salt.

In *preparing insane patients for operations* in addition to observing the most thorough surgical technique, the nurse must bear in mind the mischievous and meddlesome tendencies of many of her patients, and must be constantly on her guard to prevent patients from interfering with preparations after they have been made.

Preparation begins the day previous to the one set for the operation; in some instances several days in advance. The nurse who makes the preparation must be surgically clean and have a nurse to assist her who handles articles not aseptic. Purgatives are sometimes given. An enema persisted in until a clear return is obtained is necessary the day before the operation, and it is also well to give another the day of the operation. A specimen of urine is sent to the laboratory. The hair is washed and the scalp thoroughly shampooed. A general tub bath is given in hot water; plenty of soap and a vigorous scrubbing and rubbing are to be employed if the patient's condition admits of it. Be especially careful in scrubbing the abdomen in cases of appendicitis. Next, the part to be operated on, and a large area around it, is to be shaved and scrubbed with green soap;

the razor should be held nearly at right angles to the part; the object in shaving is not only to remove the hair but also to scrape off the epidermis; the surface should then be rinsed with sterile water, then scrubbed with lime and soda, and thoroughly rinsed again. (A green soap poultice may be applied and left on for about two hours to soften the epidermis.) The surface is then thoroughly rinsed with sterile water; then with alcohol and ether, and the parts covered with a moist dressing of bichloride of mercury (1 to 3000), or a carbolic solution (1 to 80); the sterile dressing, previously prepared, is then applied and securely fastened until the time of operation. (Just previous to the operation, this sterile dressing is removed, and the operative site washed, usually with alcohol and ether, before the surgeon begins his work.)

It is well to remember that copious drinking of water the day previous to the operation helps to prevent shock. Cleanse the teeth and mouth with boric acid solution, and have the patient cleanse the nostrils by inhalations, both the day before and the day of the event.

In cases where the abdomen is to be opened, the preparation is usually begun three days in advance, with daily warm baths, light, nutritious diet, purgatives and daily enemata, and daily vaginal douches. The shaving in these cases extends from the breasts halfway to the knees, especial care being taken with the genitals and the umbilicus. The vaginal cleansing is first of soap and water, then rinsing with sterile water followed by a douche of 1 to 4000 bichloride of mercury, after which the vagina is packed with a strip of iodoform gauze or plain sterile gauze, which is removed one hour before the operation, followed by another bichloride douche and a mopping out of the vagina with alcohol before repacking. It must be remembered that if the bowels move after the vaginal preparation has been made, the vagina must then receive another douche, and the external parts again be thoroughly cleansed. In curettage and some other minor operations, many surgeons do not require shaving of the vulva; in other cases the hair is required to be removed from the labia and perineum only, while in still others it must be removed from the upper part of the vulva also. After the vaginal

cleansing, the vulva, which has been previously shaved, is covered with an antiseptic dressing kept moist till the time of the operation.

Sterile dressings are removed on the operating table by using bandage scissors, care being taken to cut well over to the sides, so that the scissors do not come in contact with the surface rendered aseptic.

The patient should have on fresh clothing—an undervest, if the nature of the operation admits of it, a nightgown opened behind, and stockings. No jewelry should be worn. The hair, if long and abundant, should be braided in two braids well toward the sides of the head, or fastened firmly around the head if the operation is to be on the neck. The hair is to be covered with a sterile towel, or a Capelline bandage may be applied.

For *minor operations*, and especially *emergency cases*, the general bath and shampoo may be omitted, and a rapid but thorough preparation made on short notice by thoroughly scrubbing the operative site with green soap and hot water, shaving, and washing with permanganate of potash, sterile water, and oxalic acid solutions, then with alcohol and ether, after which the surface is covered with bichloride of mercury dressing (1 to 1000), thus completing the preparation.

Operations upon the insane are often demanded upon very short notice. If the nurse is in a well-equipped modern hospital, she can summon plenty of help, and she is surrounded by all the necessary conveniences, but in private nursing her resources will often be severely taxed. Wherever she finds herself, she must remember the principles underlying all the routine precautions, and must secure safety to the patient by painstaking and consistent antiseptic methods, at the same time that she must be resourceful in adapting many of the conveniences at hand to the needs of the occasion, even if she has never seen them so used before. The nurse's personal preparation in all emergency cases must be thorough, in that the essentials must be complied with, even if it must be somewhat hastily made.

In hospital service, the various nurses who are to assist at an operation will be assigned their special duties—the surgically

clean ones to "run the instruments," and to attend to the sponges and dressings; those not surgically clean to assist in various ways — to handle articles not aseptic, to assist the anesthetist, to change basins of hand solutions, to attend to the irrigator, and to wipe perspiration from the faces of the operator and his assistants with a sterile towel, taking care not to do it when they are bending over the field of operation, nor at critical times when it would interfere with important steps in the work. Nurses who are not surgically clean are on no account to touch any of the instruments or appliances that are to be handled by those immediately assisting at the operation; they are not to brush against the instrument tables, nor the gowns of the surgically clean assistants, nor to touch the arms or the hands of any of them; neither may they touch the towels or sheets that surround the wound or cover the patient or table. If it becomes necessary to restrain the patient when lightly anesthetized, nurses not surgically clean may reach *under* the sterile sheets and hold the struggling patient. It is a good rule to follow for every nurse who is to assist at an operation in any capacity to "scrub up" as though they were to be the surgically clean nurses, even though some of them, as they begin to assist, will be required to handle articles not rendered aseptic, and will thus become unfit for the more exacting services of the surgically clean nurse.

Nurses need to remember that the operating room should be as quiet as possible; that there is to be no unnecessary talking; no more moving about than is really necessary, as all moving tends to stir up dust and so to increase the danger of infection. Learn the art of keeping out of the way when not needed and on hand when needed.

After abdominal operations, even sane patients should not be left alone an instant for thirty-six hours. How much more important is this in the insane! The extreme thirst from which some patients suffer may be alleviated by means already mentioned, and frequent bathing of face and hands in tepid water and alcohol is gratefully received in most cases. The intense thirst usually disappears early in the second day, likewise the intense pain. No movement of the trunk and no turning are allowed until the surgeon gives permission. When the patient



is to be turned on the side, the whole trunk should be turned at once, to avoid twisting or pulling on the wound, the patient not being allowed to help herself in the least. It is a good rule in laparotomy cases to train the patient literally "not to lift a finger" for the first few days.

In all surgical cases a cheery, healthful atmosphere should be maintained by the nurse, who should avoid talking about illness or operations. The patient's questions as to what was done at the operation are to be met by the nurse's invariable reply that the surgeon will tell her all about it when he feels that she is a little stronger. If questions are persisted in, the nurse should say that the rules of her profession prohibit her from discussing these topics with either her patients or their friends.

Some of the accidents or unfortunate results to be looked for during or after an operation are shock, hemorrhage, hernia, and septic peritonitis, or infection of whatever part is the seat of operation. In shock the patient is dull, often in a stupor; in hemorrhage, he is restless and active. Pallor is common to both conditions, but in concealed hemorrhage the mucous membranes become more and more pale. Cold sweat is usually present in shock, absent in hemorrhage. Respiration is rapid in both conditions, but grows more and more so in hemorrhage, till the patient suffers from "air hunger"; likewise with the pulse, the rapid and weak pulse of shock improves under appropriate treatment, while that of concealed hemorrhage increases in weakness and rapidity so long as the bleeding is not arrested. The temperature may be subnormal in shock and is almost invariably so in concealed hemorrhage.

The *treatment for shock* is to remove the pillows, elevate the foot of the bed, wrap the patient in warm blankets and surround him with hot bottles, rub the extremities toward the heart, give a normal saline enema, and intravenous infusions if necessary, and stimulants as ordered.

The *treatment for hemorrhage* is to control the hemorrhage; by compression and bandage, if the bleeding is in localities where this can be done, by a tourniquet, or direct compression with the fingers in places calling for these means, until the surgeon arrives. Stimulants, as a rule, increase hemorrhage, but may be necessary

in extreme cases. If hemorrhage is in the abdominal cavity, the nurse must prepare for the reopening of the cavity in the interval of summoning the surgeon. Plenty of hot, normal saline solution should be provided, and the usual arrangements for abdominal operations made. When the hemorrhage is from the uterus or the rectum, douches and packing, and in some instances ligation, are called for.

**Minor Operations.**—In minor operations on the wards, the things likely to be needed should be arranged on a bedside table and covered with a clean towel. The nurse needs to exercise constant care to see that mischievous or suicidal patients cannot get access to the instruments or disinfectants. The bed and clothing should be protected, the hands of the nurse carefully prepared and carefully cleansed after contamination before anything else is touched.

**Skin Grafting.**—For skin grafting, which consists in transplanting living skin from one part to some part denuded of skin, the following articles are likely to be needed: antiseptics, normal saline solution, sterilized gauze, cotton, and roller bandages, safety pins, razor, scalpel, tissue forceps, sharp curette, two artery forceps, two cambric needles, aseptic rubber tissue, some of which is cut in narrow strips.

The nurse will thoroughly disinfect the skin from which the grafts are to be taken, the day before the operation, and on the removal of the sterile dressings previous to the operation, will rinse the surface with saline solution, and hold herself in readiness to assist as otherwise needed. The wound is washed with saline solution before the grafts are applied. The physician may require the nurse's help in spreading the grafts on the wound, and the strips of rubber tissue over them. A compress moistened in saline solution and the bandage are then to be applied.

**To prepare a Patient for Lumbar Puncture.**—By lumbar puncture is meant the withdrawal of cerebro-spinal fluid from the spinal canal for the purpose of studying its composition chiefly as an aid to determining the diagnosis in certain mental and nervous disorders. It is thought to have a curative or at least a beneficial effect in some cases as well. This operation is a simple one, consisting of tapping the space between the mem-

branes of the cord which contains the cerebro-spinal fluid. The puncture is usually made in the fourth lumbar interspace, about in line with the highest point of the hip bones. At this point there is no danger of touching the spinal cord with the needle.

The patient's skin in the lumbar region should be surgically clean as well as the needle used for puncture. The patient may be either sitting in a chair or on a table, well toward the edge, and leaning well forward, or may lie on his side in bed, his body brought close to the edge of the bed, the head on a pillow, the thighs flexed on the pelvis. Ethyl chloride is sometimes used as a local anesthetic. The needle, a fine wire to clear the needle, a small rubber tube, a spirit lamp, three test tubes, a small pus basin, collodion and dressings, are all at hand on a tray covered with a sterile towel. The fluid may gush out with force, or issue drop by drop; it is received into three different tubes for further examination in the laboratory. After the withdrawal of the needle, collodion is applied to the punctured skin. The patient should rest in bed twelve to twenty-four hours after the operation to avoid the headache and weakness that sometimes follow lumbar puncture. Rarely vomiting occurs after the operation. Normal cerebro-spinal fluid is clear. If the fluid is bloody, or if only clear blood escapes, the puncture will need to be repeated in another place, or at a later time.

## CHAPTER XV

### CARE OF GYNECOLOGICAL AND OBSTETRICAL CASES: PUERPERAL INSANITY

THE duties of the nurse in gynecological cases are as follows: to prepare patients for examination; to assist at examinations and treatments; to carry out the instructions for treatment; to prepare patients for operations and assist at the same; and to give the appropriate after-care.

By local treatment we mean the giving of vaginal douches and sitz baths, the use of tampons, and of topical applications. To the nurse is intrusted the giving of douches and baths.

**Preparation of Patient for Examination.** — When a patient is to be examined gynecologically, the nurse's duties in preparing her are of a manifold nature. In the first place, the nurse must bear in mind that for a woman to submit to an examination of her pelvic organs, even by a woman physician, is an ordeal, and that most women, both sane and insane, shrink from it as we all shrink from an unknown dread. The insane, too, are often especially apprehensive, and the least thing out of the ordinary fills them with unreasoning fear. The nurse should remember this, and by tactful words of persuasion pave the way for the examination. If the case is one in which it is not yet known whether pelvic disorders exist or not, and the examination is to be done as a routine measure, just as the heart and lungs and other organs are examined, the nurse may say to the patient that the woman physician wishes her to come to the examining room that day that she may learn if any condition of those organs exists needing treatment; that if no such condition is found, she will not need to go again, and that if such is found, the doctor can probably relieve her by local treatment so that the general health will improve also. Some such preparation

as this will go far to develop a right attitude toward the examination, and should not be neglected on the part of the nurse as she begins her physical preparation of the patient. After patients have once been to the examining room, they are, as a rule, tractable and reasonable about the matter. Timely explanations, as suggested, will often counteract the effects of certain busybodies among patients who seem to delight in frightening newcomers with the various means of treatment in store for them.

The body of the patient should be scrupulously clean, especial attention being given to the vulva and anus; the underwear should be clean also, and the rectum and bladder empty. It is well to give an enema, even if the bowels are not considered constipated, as insane patients are so unreliable in this respect, and it is exceedingly annoying to the physician to have a patient put upon the table only to find that the rectum is so full that a satisfactory examination cannot be made. If the patient objects to the enema on the ground of its being unnecessary, explain to her that there may be an accumulation higher up, and that you wish to make sure that the passages are thoroughly evacuated. Have the patient urinate shortly before going to the examining room. A vaginal douche should not be given, as a rule, before the first examination, as the physician usually prefers to see the exact character and amount of the uterine and vaginal secretions. After the initial examination, vaginal douches are usually in order, the quantity, character, and temperature being modified to suit individual cases.

Nurses who accompany patients to the examining room should be prepared with pad and pencil to take down instructions regarding the time of removal of tampons in each case, the temperature of douches, and other special instructions.

The charge nurse should send with her patients a nurse who is conversant with certain important facts in the case — the full name of the patient, her general behavior, her special physical complaints, such as leucorrhea, backache, headache, and the like, her habits as to masturbation, if such exist, the facts concerning her menstruation, the time of the last period, the regularity and quantity of the flow, and whether or not pain or other



conspicuous symptoms are present during the menses. It is inexcusable for a charge nurse to send a patient to the examining room with an attendant so ignorant of the case that this information, if necessary, cannot be elicited from her.

Each patient should be provided with a toilet napkin and safety pins and, if medicated tampons are inserted, these napkins should be applied immediately after the patient descends from the examining table, in order to protect the clothing from being wet and stained by the applications made. Dull or feeble patients require the nurse's assistance in properly adjusting napkins. Where glycerine or boro-glyceride are used, the napkins in some cases require frequent changing, as the use of these substances is followed by excessive secretion from the parts, and unless precautions are taken, unsightly and unnecessary staining of the clothing takes place when certain other medicines are incorporated in the mixtures.

In taking several patients to the examining room, especial supervision needs to be exercised that suicidal or mischievous ones do not slip into the operating room, or the rooms where supplies are kept (in case such rooms are in close proximity), and so perhaps obtain means for injuring themselves or others. And when in the examining room, the nurse must be on her guard to see that patients do not gain access to the bottles of medicine, or disinfectants, or the instruments, and that violent or meddlesome ones do not interfere with the examining table or other objects in the room. Some angry and belligerent patients will, unless prevented, sweep a whole row of bottles from the table, seize and break the foot rests, grab at the instruments, or attempt to do violence to the physician, especially when the head is in close proximity to the patient's heels while treatment is in progress.

In hospital work the nurse should see that the patient removes her corset, if one is worn, before going to the examining room, and wears open drawers. All tight waistbands should be loosened before the patient is assisted to mount the table. The use of the sheet to cover the patient should never be omitted, whatever the position used, even if the patient herself seems lost to all sense of modesty. This sheet should be scrupulously

clean; it is variously draped, according to the positions employed. Any method of drapery easily and quickly applied, and which affords protection from unnecessary exposure, and does not interfere with the physician's work, will usually be acceptable. Some patients are so violent and resistive that all efforts to protect them from exposure are almost fruitless; in such cases the nurses have to help maintain the necessary position, as well as to guard against violence.

Pains should be taken to keep the instruments out of the patient's sight, and all other things as well that would cause apprehension, or be offensive in any way. Care should be taken to avoid unnecessary noise in handling the instruments; some nervous patients almost get into a panic at the sight of the long dressing forceps with a piece of cotton attached. The soiled towels should be gathered into the hamper before the patient is allowed to rise from the table. The trays containing the bits of cotton used during the treatment, as well as those holding the instruments, should be covered, or, if on swing doors on the table, closed in out of sight before the patient descends from the table, and pulled out into place for the convenience of the physician after the next patient is arranged on the table.

Due care should be taken in assisting a patient on and off the table not to let her slip, nor get her clothing caught in the foot rests, nor to let the clothing or the cover sheet get wet at any time by falling into the trays containing the antiseptic solutions for the instruments.

When patients are put in the recumbent position, the nurse should herself raise the patient's feet to the stirrups, and in helping her to dismount, the patient should be told to turn on the side before rising from the table, so as to avoid unnecessary strain.

The nurse will learn from practical demonstrations how to prepare the patient for the various positions used in examinations and operations. The erect position, the dorsal recumbent, the lithotomy position, Sim's position, and the knee-chest position are the ones most likely to be used.

Since the dorsal recumbent position is the one most frequently used, we shall consider it in some detail. The patient is told to

face the nurse who stands at the foot of the table and to step upon a low stool at the foot. The nurse holds a half-open sheet before the patient at a level with the hips, the patient being instructed to lift her skirts behind and to seat herself close to the lower end of the table. The sheet is then laid over the patient's lap and she is assisted to lie down; the nurse places a small pillow under the head, adjusts the feet in the stirrups, and separates the knees as far as possible. Until patients become accustomed to taking the position, they will always sit too far back from the end of the table; most of them will have to be told to lift the hips and let you draw them down so that the buttocks slightly project over the table's edge, as this is the position best suited to the convenience of the physician. The lower part of the sheet is then folded under the edge of the skirts, and after being pushed upward some distance, skirts and sheet are folded inward toward the abdomen. A folded towel is placed under the buttocks to protect the clothing and table from the medicines used. At any time when patients are on the table, if there are pauses or interruptions in the work, the drapery should be dropped temporarily so as to conceal the genitals from view.

The duties of nurses in assisting the physician at gynecological examinations vary according to the number of nurses provided, the customs of the physician, the character of the patients and their condition, and also according to the degree to which antiseptic technique is enforced. In New York State hospitals, where there are classes in training, the clinics are usually so arranged that the pupil nurses take their turn in the various offices required of them — in assisting the patients on and off the table; in learning to pose and drape them in the different positions; in preparing and handing the instruments and in washing and disinfecting them; in washing the genitals with an antiseptic solution just previous to the ocular and digital examination; in lubricating the speculum and in medicating the tampons; and in rendering whatever other assistance may be required. Where there are several nurses to assist, one nurse, as well as the physician, keeps surgically clean, the other assistants handling articles not aseptic. This surgically clean nurse

should observe as strict technique as though she were assisting at surgical operations; the training thus pursued is excellent preparation for the gynecological operations at which she will assist later.

The nurse can help much during the digital examination by keeping the patient's knees separated, the clothing and drapery from getting disarranged and in the physician's way, and by encouraging the patient to breathe deeply, preferably with the mouth open, and so relax the tension of the abdominal muscles.

The physician will indicate the kind and size of speculum to be used. The nurse, if surgically clean, lifts the speculum from the tray, lubricates the outside of the blades, and hands it to the physician in the direction in which it is to be used. Or if she is nurse-of-all-work, so to speak, the tray is arranged in reach of the physician, who lifts the speculum himself and applies the lubricant to it. If lysol is used in the instrument trays, a lubricant is unnecessary. A speculum should be neither too hot nor too cold nor too much anointed. Uterine forceps with bits of cotton are then needed to clear away secretions that may be seen on the vaginal or cervical mucous membranes. Other assistance will depend upon the nature of each case.

If the physician calls the attention of the nurse to any condition about the patient, or tells her to look in the speculum, or if in any way the nurse obtains information about conditions, she must be on her guard to avoid expressing surprise or consternation at what she learns, either by voice or facial expression, as nervous patients are easily made more nervous by chance remarks of nurses and physicians. An "Oh, my!" or a look of pity or of surprise at perhaps merely a cervical erosion which an inexperienced nurse sees for the first time, may make the patient think that she has some serious thing the matter with those parts, and that the physician is keeping her in the dark about it.

In gynecology, douches are given for cleansing purposes, to relieve inflammation, to check hemorrhage and secretions, and for purposes of stimulation. They should be given carefully, with conscientious regard to quantity, temperature, and other specifications.

Especial care is necessary in the giving of douches and enemata after perineal operations not to press the nozzle of the syringe against the repaired tissue, but against the opposite wall. Sterile douches may be ordered every twelve hours after perineal cases, and twice a day after cervix operations. It is important that the vagina should be dried after douching in perineal cases, by using cotton on forceps, so as not to soften the stitches. Vaginal or uterine packings of sterilized or medicated gauze are usually left in for twenty-four or thirty-six hours after operations, removed with sterile forceps, and followed by a sterile douche, if ordered. When packings are placed, the temperature is usually taken every two hours, and if it reaches 101° F., the packing is removed.

In cases where a catheter is left in the urethra for some days after operations, it is to be removed and cleansed every few hours; a second aseptic catheter should be at hand to replace the one removed.

**The Care of the Pregnant Woman.** — After the seventh month, the urine should be frequently examined. Swelling about the eyes should make one suspicious of the presence of albumen. In such cases the diet needs to be restricted to milk chiefly, and the quantity of urine carefully watched, as convulsions at the time of confinement are to be feared. Saline enemata, warm baths, copious drinking of water are remedial measures in this condition.

The nipples should receive preparatory treatment. If the breasts are so heavy as to need support, they may be comfortably bandaged, leaving the nipples uncovered. The nipples should be washed daily with warm water and soap and anointed with a little cold cream. If they are inclined to be flat or retracted, an attempt to develop them should be made by drawing them out with the thumb and finger, or a breast pump may be used toward the later months of pregnancy. Some physicians order daily nipple baths of alcohol and water to prepare the nipples.

**Threatened Abortion or Miscarriage.** — If at any time during pregnancy the woman has even a slight flow of blood from the vagina, she should go to bed and keep as quiet as possible, and send for her physician if it continues. If the bleeding is at all



conspicuous, the head should be lowered, the hips elevated, the foot of the bed raised, hot drinks avoided, and perfect quiet maintained. If the flow becomes alarming, a hot sterile douche (110° to 115° F.) may be given. The strictest antiseptic measures are necessary in these cases. All blood and blood-stained sheets or cloths should be saved for the inspection of the physician.

**Management of Pregnancy.**—It happens on rare occasions that the nurse finds herself in a position where she has to conduct the labor alone, the labor being so precipitate that the physician cannot be summoned in time. If confronted by this emergency, go about it calmly, not letting the patient know that you are not accustomed to render such service. The patient should lie upon her left side at the edge of the bed, the thighs being drawn up and a pillow placed between the knees. Thoroughly cleanse and disinfect your hands, and have a basin of bichloride of mercury (1 to 2000) and gauze or linen sponges within reach. Place a gauze sponge over the anus. As the head comes down, your hand should gently support the perineum; encourage the patient to cry out, or to open the mouth widely as the head presses the perineum. Receive the head in one hand, supporting it so that its weight does not drag upon the parts; with the other hand wipe out the eyes and mouth, and patiently wait, without pulling, until another pain comes and expels the child, which you will receive in the unoccupied hand. As soon as the head is born, pass your index finger to the neck to feel if the cord is around the neck; if so, pull it out and slip it over the head. When the body is expelled, turn the child on its right side, taking care to put its face out of the way of the discharges from the mother, lay a blanket over it, and leave it there for a little while, turning your attention to the uterus to aid its contractions. Grasp this organ through the abdominal walls, and rub gently or squeeze it for a little while to make sure of its contracting. When the cord has ceased to beat, tie it with two pieces of aseptic bobbin, then cut the cord with surgically clean, dull, and preferably blunt-pointed scissors, taking care not to injure the baby if it is kicking about during the procedure.

If the child fails to cry, strike the buttocks or the bottoms of

the feet vigorously, or dash cold water on the chest, or rub alcohol or vinegar on the pit of the stomach, or moisten the lips with the finger dipped in alcohol. If these methods fail, artificial respiration will need to be used. After breathing is established, it is well to place the child in a warm bath and use gentle friction till the skin becomes reddened. Then wrap the child in a warm blanket and put it on its right side in a warm, safe place until you have leisure to attend to it further.

Soon after the child is expelled, turn the patient upon her back and grasp the uterus as before stated.

When the placenta is seen at the outlet, grasp it and draw it gently downward and backward in a rotary way so that the membranes will twist on themselves as they come away; do not pull on the cord or the placenta, nor put your fingers in the vagina. The placenta is to be saved for the inspection of the physician, also all clots and discharges. After the placenta has come away, the uterus usually contracts still farther, there is but little oozing of blood, and the patient can soon be bathed and made comfortable by clean dressings and a binder, and allowed to sleep. The pulse usually drops after labor to about 80 or less; if it continues at or above 100, hemorrhage is to be feared.

Convulsions occurring during labor usually call for the speedy termination of labor. Chloroform is given during the convulsions, and if labor is not advancing rapidly enough, the child is delivered either by turning or by instrumental delivery. The nurse should try to prevent the patient from biting her tongue during convulsions. The administration of chloroform for partial anesthesia is, in these cases, usually intrusted to the nurse. A few drops are put on a folded handkerchief, and the latter held over the nose only during a pain, or a convulsion, as the physician directs.

The main thing in nursing during the puerperal period is to keep the patient clean, quiet, well nourished, comfortable, and cheerful; to give the baby regular and sufficient care, and to let it sleep as much as it will when not being bathed, fed, or otherwise attended to.

The patient's temperature, pulse, and respiration should be

taken and recorded morning and evening for two weeks, or longer if it does not run a normal course. The amount of nourishment, the condition of the bowels, bladder, breasts, and the lochial discharge, are matters concerning which full reports should be made to the physician. The nipples should be bathed after each nursing with a boric acid solution, and the child's mouth washed before and after each nursing.

**Morbid Excitement or Depression during Pregnancy.** — (Puerperal Mania or Melancholia.) One or the other of these conditions may come on during pregnancy, or immediately after confinement, or later, during lactation, when the woman is exhausted with nursing the baby, with worry, or with physical ill health.

Alterations of character, not amounting to insanity, may occur during pregnancy; for example, fretfulness, forebodings, capricious conduct, craving for unnatural and even disgusting things, and these may be accompanied by jealousy and suspicion of the husband, or of those who have the immediate care of the patient. These unusual symptoms may go no farther in some cases, but in others may be the forerunners of graver morbid manifestations that show themselves just before or shortly after confinement.

Perhaps a few days after confinement the nurse will notice that the patient is unusually talkative, restless, capricious; she sleeps but little, her appetite is poor, and she seems indifferent to, or even actually shows dislike to, the baby. These symptoms call for the closest vigilance and the most careful nursing. They are most often found in company with infection symptoms, especially in patients with a nervous or insane heredity. They are likely to go on to more and more pronounced symptoms of either excitement or depression, and the nursing has to be directed toward counteracting the exhaustion that is likely to follow.

As the child is usually taken from the mother and fed artificially, the breasts require the usual care of emptying and bandaging to cut off the supply of milk.

Whether the condition is one of exaltation or depression, the child's life is usually unsafe when near the mother, and its pres-

ence, as a rule, only serves to aggravate her condition. Some insane patients attempt to destroy the child while it is being born; a case in mind tried to choke the child between her own thighs. Some patients give no sign that the labor is in progress till it is well on toward completion. In one instance I have in mind, the first intimation the nurse had that the patient was in labor, she heard the child cry, and searching for it, found it lying in the bowl of the water closet.

Patients in these unnatural mental states accompanying pregnancy, or the puerperal period, are often suicidal and very shrewd and sly.

The patient must not be left alone an instant day or night. She may feign sleep in order to get the nurse off her guard. The windows must be guarded, doors locked, all medicines, instruments, and disinfectants kept under lock and key, and everything removed from the room with which the patient could in any way injure herself or others.

Abundant nourishment and antiseptic nursing are the most important features of the treatment. Forced feeding may have to be resorted to.

Your experience with the insane in general makes it unnecessary to dwell longer on these conditions, since to obstetrical nursing you have but to add the care you would give to uncomplicated cases of excitement or depression, as the case may be.

## CHAPTER XVI

### OCCUPATION AND AMUSEMENT OF PATIENTS

IT is an uncomfortable reflection, but one that often forces itself upon me, that many patients now considered hopelessly deteriorated, could have been saved from drifting into the depths of dementia in which we see them, had their hands been kept occupied, their muscles trained to regular tasks, and their intellects stimulated by interest in some wholesome work.

It should be remembered that idleness of the mind is as great an evil as that of the body. There are patients that are kept at a daily round of tasks as in a treadmill — tasks to which no interest, no joy in the work, and no intelligence, is brought — just automatic accomplishment of certain routine things they have been trained to do. But even that is better than sloth, and that is perhaps all that certain ones are now fitted for. It is not intended to belittle such work if patients are incapable of more intelligent occupation. We need to remember that even this automatic employment is useful, in that it keeps their bodies exercised, it expends muscular energy that would probably otherwise find its outlet in noise, mischief, violence, or destructiveness; it lessens the great army of the unemployed, thereby reducing the disheartening effect on every one who witnesses the large body of idlers; and lastly, its economic value, in the actual work accomplished, is of importance, although we need always to bear in mind that this is the least important reason we have for urging the occupation of patients. They are to be urged to work when and only when work is good for them, and not because the work is there to be done. Willing workers must not be overtaxed, and intemperate workers must not be allowed to go to the excess that some of them are prone to unless safeguarded. Supervision to prevent overwork is as important, though less frequently needed, as is stimulation of the slothful.



Occupation is an important part of the treatment of the insane, and should receive more systematic attention than it does at present. Each patient should be studied in this respect, his strength, his age, his previous condition and station in life, his tastes and capabilities — all these considerations entering into the choice of the work assigned him. If due attention be given to these things, with the exception of the physically weak and depressed, the acutely maniacal, and the infirm, there is scarcely a patient but will be materially benefited by regular, systematic, and judiciously prescribed employment.

There is no remedy for the evils arising from sensuality equal to that which cultivates an intellectual interest in things. Patients who have become self-indulgent to the point of sensuality usually get dull and inactive; and gluttony, masturbation, and other perversions follow. Bodily exercise for such cases is excellent so far as it goes, but it needs to be supplemented by things that will stimulate the mind if we hope to prevent or to eradicate these vicious propensities.

A congenial occupation demanding one's attention furnishes a healthy channel for the thoughts, and thus morbid fancies get crowded out. Even in the physically weak and infirm, where the bodies must remain inactive, it is well to furnish some light occupation for the mind, suited, of course, to each case. A few minutes' reading to such patients, some bright anecdote or short story, some description of travel that will give them food for healthful thought throughout the day, some interesting details in the lives of men and women engaged in the world's work — accounts of human achievement; selections along such lines, made by a thoughtful nurse, and either read by her, or by some one whom she designates, will do much to entertain, and perhaps to restore to mental health. For it is the getting away from self, the keeping of the mind interested in the big world of which we are a part, and the keeping alive the feeling of brotherhood, that helps us all to maintain healthy interests; and if these are dormant, such means will help to awaken them, and so crowd out morbid fancies, and leave little time for harmful propensities.

Patients who have poor eyesight, or those who, for any reason,

cannot read, should receive special attention in the matter of being read to and entertained, and of having letters written for them. Nurses can often enlist other patients in this service, and so kill two birds with one stone; the one who reads is benefited as well as the one read to, perhaps more so.

There should be variety in occupation; monotony is wearisome and deadening, while variety is assuredly the spice of life. Avoid getting in ruts yourself, or letting your patients do the same. Unless watched, some patients will show undue zeal in Bible reading, in piano practicing, in card playing, in embroidery, or in whatever pursuit they develop an interest. Tact in breaking in upon their monotonous occupations needs to be exercised. But unless monotonous ones are broken up, they cease to be helpful, for when so nearly automatic as some of them come to be, they lose their beneficial effect upon the mind.

Nurses need to remember that new patients must not be set to work until their occupation in kind and degree is sanctioned by the physician. But do not let the physician lose sight of this. Call his attention to the unemployed, and secure his help in initiating occupation, should he fail to attend to the matter after sufficient time has elapsed to observe the patient.

In all occupations, nurses and attendants need to keep constantly in mind that their patients and their work must be supervised conscientiously in order that no tools or objects that could be used as weapons shall be allowed in the hands of patients who cannot be trusted with them.

Attendants, when supervising work of patients, should become party to that work. It is inexcusable for them to sit idly by, or to walk or stand about, giving their orders merely, while enjoining industry on the part of others. Where the work is such that a general supervision must be kept up, the attendant cannot always work steadily, but the really efficient one will find means for lending a hand here and there and making the patient feel that he is practicing industry as well as preaching it.

A cheerful attitude toward work is contagious, and all who have the direction of patients in this particular can do much to make of occupation a pleasure. Begin the day's work with a cheery manner, let jest, banter, and even good-humored raillery

abound, encourage patients to talk, to sing, to whistle, and to have a good time while working. In so doing, you will guard against the feeling that work is irksome.

I hope the time will come when, in addition to the various industrial shops in vogue in some hospitals, there will be regular schools where the truths in kindergarten methods will be made applicable to patients; courses of instruction adapted to the needs of various classes and conditions will help in upbuilding mental health; workshops where various handicrafts will be taught, and gymnasias where body building will be regularly and systematically attended to.

I wish to emphasize the necessity for individualization in the choice of occupation, the particular work being suited to a given patient, and to the patient's existing condition. Never allow him to jog along day after day in work which, though it may have been suited to him at one time, is now, by reason of advancing age, or poor health, or for any reason, no longer adapted to his strength.

Patients should, in general, be encouraged first to do all they can to help themselves, and then to do something each day to help others. To begin with, they should be trained to look after their own persons, their bathing, care of the hair, attention to nails and teeth, to their bodily functions, and to dressing themselves and keeping their clothes brushed and mended and neatly arranged. They should air and make their beds, keep their rooms tidy, and be encouraged to do things to add to the attractiveness of their rooms. Women patients can, by various little touches, give a homelike air to their surroundings, and many men show a like aptitude. Still others undoubtedly would if they were encouraged to do so. Stand and bureau covers, picture frames, book shelves, pillow shams, baskets, slumber robes, artificial flowers, braided mats and rugs — these are a few of the things that come to mind that patients can make or arrange to add to the attractiveness of their rooms. It is often surprising what ingenuity and resourcefulness some of them evince in these directions, often making unique and artistic things from very simple and unpromising materials.

Basket weaving offers a most absorbing occupation for many

women, and the nurse can often do much to interest friends of patients to supply them with materials for such work.

Some patients can be interested in saving magazine pictures, and with a passe-partout outfit add to the attractiveness of their rooms. Others make scrapbooks and picture books that are a source of real interest to themselves and others. These are especially acceptable in the hospital departments.

Interesting picture frames can be made of acorns and acorn cups, beechnuts, birch and other barks. Attractive and inexpensive splashers and bureau covers can be made from silkline, dotted muslins, scrim, burlap, denim, and the like, the patient often following out a certain color scheme that gives the room a harmonious and individual atmosphere.

In these days so much can be done with carpet rags that it seems a pity not to keep patients at sewing rags, even if they won't do anything else. Men patients find welcome outlet for their energies and capabilities in work on the farm and in the garden, in the various shops, the laundry, and other like places. The women can also be employed in the laundry, the kitchen, the sewing rooms, and on the wards, and they are always the happier for occupation which makes them feel of use, and in which they can be trained to take a personal interest, although at the start many of them have to be roused from the inertia into which they have fallen. This rousing is where the intelligence and patience of the nurse come into play. Patients incapable of any other occupation can be trained to pick hair for renovating mattresses.

You can often give a festive air to what might otherwise be a dull, uninteresting task. Suppose a certain lot of needlework has to be done in a given time. Invite your patients to a sewing bee or a thimble party at a certain day and hour, the affair to be heralded, perhaps, by a humorous placard posted in the hall; carry the thing through with fun and nonsense; serve a cup of tea or cocoa in the afternoon, and while the time away, besides sewing, in various ways which your own ingenuity will suggest if you really set about it.

A lot of fun can be got out of simple things, and a good laugh and pleasant recollections called up by the veriest nonsense. For example, with a party of assembled patients sewing and

chatting, you can, by way of diversion, start them to recalling and reciting, in turn, nursery rhymes, or Mother Goose melodies, perhaps making them pay forfeits for failure to respond or to quote correctly.

Another time have autograph album verses, or bits of poetry quoted, or cast lots and have one tell a story, or have some one tell what she can remember of the best book she ever read, or have them mention their favorite old songs, each one seeing who can recall the largest number. All this can be done without interrupting their sewing, as any one who has attended thimble parties knows that tongues and needles can fly simultaneously. These few suggestions will not be applicable to all patients, nor at all times, and their employment will require tact on the part of the nurse, but they, and many others that will suggest themselves to you, will be applicable at times, and will, I believe, if put in practice, contribute largely to the pleasure and jollity, the home atmosphere, the harmonious working together, and so to the well-being of your patients, and oftentimes, even to their restoration to mental health.

Sunday nights on the wards should be especially marked by a little cheerful social intercourse, the singing of favorite hymns, perhaps a Bible reading, or Bible quotations, Bible charades, a Sunday-school class, and the like. I have known of most interesting Bible classes conducted by a patient or patients for months at a time, and made a source of much comfort and interest to a large number.

If you have a German or a French patient on your hall who can be enlisted, you can often start a class in the study of these languages, not necessarily in a formal or very ambitious or very thorough way, but very simply and in a way adapted to the needs of the ones to be taught and of the ones who teach — perhaps just teaching them the names, for example, in German, of the common articles about them, parts of the body, furniture, food, and table utensils, the alphabet, how to count, the months and days, and such simple things. Then encourage them to put their acquired knowledge in practice at the table and on the wards. This will not only interest and stimulate their minds, but will add to the feeling of fellowship between them; it will



make the foreigner one with them, and will make them feel that they are acquiring something outside the daily round of things.

Chess, checkers, dominoes, billiards and pool, cards of various kinds, word games, puzzle maps, Halma — these and others all have their places, and should be intelligently enlisted in the amusement of the patients. Baseball, basket ball, croquet, and tennis are games easily pressed into service.

I have unconsciously drifted into the subject of amusement when writing of the occupation of patients, but that is as it should be — work and play blended, and plenty of play mingled with the work. All work and no play makes Jack a dull boy, and it is particularly bad for Jill, too. Many of the Jills under our care come here because their lives have been one dull round of work, with no time for the brightening and wholesome influences of play.

It is a lamentable truth that not a few of our patients have always led such treadmill lives that their first experience with fun and a good time has come to them within the walls of a hospital for the insane. Some of these, on the eve of going home, have even been known to sigh and say, "I shall miss the dances and the other good times I have had here"; and these not, as one might imagine, the young and giddy, but staid middle-aged matrons who have here seemingly learned for the first time in years what it is to relax and really have a little fun.

Some of your patients have never learned to read. Not that they do not know how to read, though, of course, this is true of a number of them, but I mean that they have never acquired the habit of reading, some from lack of time, others from lack of inclination. Here is your chance, at least with those who have heretofore had but little time for reading, to encourage them to acquire a love for reading. The habit of reading is a very present help in trouble. Be careful how you belittle the days when it is your ward's turn to send patients to the library. Reflect what power there is in a book, and be active in stirring your patients to a lively interest in the selection of reading for themselves and for other patients who are unable to leave the ward.

I have known a chance sentence read from a book to be the carrier of hope to one in the Slough of Despond; I have known the

sight of a beautiful picture to be a heaven-sent message to a beclouded mind; and the hearing of good music, sympathetically played, to be the key that unlocked an imprisoned soul, letting it out into sunlight and peace once more. Then let us be awake to all the influences that can be brought to bear on the sick bodies and minds intrusted to us, remembering that the mildest power is often the greatest, and that a seemingly little thing may have an incalculable effect on that complex thing, the human mind.

On days when the weather admits of it, see to it that every patient who is able goes out of doors. Do not allow the sedentary and the apathetic to mope day after day indoors when the health-bringers, fresh air, sunlight, and exercise, are so close at hand.

It may require considerable tactful effort on your part to establish the habit of going out in certain ones averse to it; but when it is established, it will help to sweep the cobwebs from their brains. And when you are out with patients, seek to make their daily walks a source of interest and benefit to them. You know that the rules require, in substance, that you are to see that each patient going out for exercise is neatly and suitably clad, according to the season, and that you know how many and who are under your care; that you are expected to exercise especial supervision of the untrusty and the vicious; that stragglers are not to be permitted to stray too far behind; that feeble ones are not to be taxed beyond their strength; that unseemly conduct is to be prevented so far as possible; and that your charges are to be safely returned to the wards, being counted in as carefully as they are counted out.

Is your whole duty done when these things have been accomplished? I admit that to do these things enumerated, with a certain class of patients, requires about all that the nurses and attendants can compass; but there are times and seasons, and with certain classes of patients, when much more can be done, and the nurse who will cultivate in herself a love for out-of-door life will find ways and means for communicating her love and interest in these things to her patients. One need not necessarily take up a serious course of nature study, though a more wholesome and rejuvenating pursuit can hardly be found; but can simply begin by learning to see with a fresh eye and feel keenly

the common beauties of the sky, the grass, the trees, the distant hills, the wayside flowers, the ever-changing light and shade on the face of Nature, and the infinite variety unfolded from hour to hour, and day to day, throughout the varying year.

Be on the alert for fresh arrivals in the birds, catch their first calls in the spring, attend to the brown earth as it begins to be pierced with all manner of green things that unfold from day to day, let your glances flit about with the butterflies that hover near, learn to be stirred by the promise of awakening spring, exult in the radiance and beauty of summer, bask in the mellow fulfillment of autumn, and respond with briskness and vigor to the challenging forces of winter, and so become at one with Nature in all her changing aspects. When you are yourselves alive to these things, you cannot help making your patients keenly aware of them also, and you will put your wits to work to see what each walk can bring of pleasure and stimulation to your patients.

Begin by teaching them to observe. It is surprising how few people really use their native powers of observation, how few, though having eyes and ears, really see and hear.

A spring walk can be made very full of interest by asking each one to see how many signs of early spring each can discover, by sight or sound, or whatever sense it may be. Watch for the music of the swollen brook, the first bluebird's note, the yellowing of the willows, the appearance of skunk's cabbage, the blossoming of the hepatica, the swelling of the tree buds, and the unfolding of the various flowers in their turn as the season advances. When they become abundant, appeal to the love of collecting, so common to many people, and interest them in seeing, for example, who can gather the greatest variety of leaves in a given walk, or the largest number of flowers, or who can note the greatest variety of birds, and identify their songs, and perhaps find their nesting sites. When these are found, the amount of interest in the building of the nests and in the rearing of the broods is a most absorbing source of delight. Right on our lawns are exceptional opportunities for these observations, and in the woods, in the rear of the buildings, through which your daily walks take you, are more varieties of flowers than are

dreamed of in your indifference, unless you have really attended to these things.

The various leaves and flowers gathered can be later identified and studied with the help of books from the library, and the help of others who are farther on in the study of these things than you are. Attempts at drawing the leaves can be made, and furnish much amusement, and often lead to an interest deeper than mere amusement, for dormant capabilities may be discovered in persons ignorant of any ability in this direction.

Let me mention a few books that may help you in these studies: Parkhurst's "Bird Calendar," Mrs. Dana's "How to Know the Wild Flowers" and "According to Season," Francis Theodora Parsons's "How to Know the Ferns," Marshall's "Mushroom Book," Gibson's "Sharp Eyes," Neltje Blanchan's "Nature's Garden," Dugmore's "Bird Homes," and Keeler's "Our Native Trees." Then there are the delightful essays of outdoor life to be found in the works of John Burroughs, which are in themselves invigorating and inspiring as is Nature herself, as well as many other books on kindred topics which are to be had by applying for them at the library.

There are other expedients to be tried, too. A lot of fun can be had in early spring by making up a party and going for "greens," going to some moist meadow for cowslips, to the fields for narrow dock or milkweed, on the lawns for dandelions, and to the brooks for water cress. The delight of these excursions, the infrequency of them, and the toothsome flavor that the gathered products yield in the dinner later, are all beneficial to a marked degree. Another spring pursuit, that ought to appeal to the poetic sensibility of the most prosaic, is the spring pastime of gathering dandelions for wine.

It is a good plan on all the wards, but especially on those where tubercular patients are located, to make frequent occasions for practicing lung gymnastics. This can be done on the balconies and in the sun rooms, and it is particularly desirable that it be done frequently when out for walks. Suggest to your charges, "Let us see who can expand the chest the best." Then instruct them how to begin, by inhaling a deep breath through the nose and take, say, three steps while holding it, then slowly let it



out, through the nose also; next time hold it for five steps, then for eight, then ten, and so on, till each one in her effort to excel finds herself filling her lungs with pure air, as they are seldom filled, thereby increasing her sense of well-being and her actual good health, while she is only conscious of having some pleasurable change in a customary exercise, a change that has added zest to it by means of this simple expedient.

Did you ever hear of a "Giggle class"? Even this, as silly as it seems, may be made beneficial, and it certainly is amusing. Ten persons are asked to stand in a circle. Beginning at one point, one says "Ha!" the next follows, and so on around. The next time around, "Ha, Ha!" more rapidly, and again more Ha's and still more rapidly, until all lose their turn in their effort to catch it up, and so, what started out to be a mechanical giggle, becomes a downright laugh in good earnest in all round.

Some of these suggestions may seem very trivial, but at the risk of their appearing so, I mention them with the hope that, even if the ones suggested are not tried, they will at least put you in mind of others that may appeal to you as better and more suited to the particular cases with which you have to deal.

Sometimes exercise is not the thing to be recommended; in certain cases just the opposite is to be enjoined. With some agitated and restless patients your help is needed to quiet muscular activity, and here you are often confronted by a difficult task. Sometimes you can gain a patient's attention and induce her to sit perfectly still for at first one half minute, three quarters, one minute, and so on, gradually, as success in the shorter periods is obtained. You can teach those who are in the habit of holding their muscles tense, and of assuming strained attitudes, to relax them, even for short periods, and so, perhaps, in time, effect a decided improvement in these abnormal muscular habits.

You can teach simple finger-and-wrist motions, and also direct coarser muscular movements later, which will relieve the nerve tension caused by the finer muscular movements. Those patients who are engaged in one kind of employment pretty steadily should receive intelligent attention in the choice of their amusements, so to see that different groups of muscles are brought into play than those they have already exercised.



On days when it rains, or when for any reason your patients are prevented from going out of doors, try what you can do to give them some pleasurable exercise indoors. Unless you do, a fretful, peevish, quarrelsome time may be expected.

A bean-bag exercise is an excellent thing; even a pillow fight is better than less harmless altercations that will assuredly arise unless a legitimate outlet is provided for pent-up energy. Care must always be taken to prevent vicious patients from hurting others, or mischievous ones from carrying their fun too far, as they are often inclined to do. A crane walk is another means of getting plenty of exercise and lots of fun in the bargain. Have a certain number form in line and hop about on one foot, following the leader. As soon as the leader makes a mistake, he goes to the foot, and the next in line seeks to see how long he can hold his place. Or, try simple exercises that call for some rivalry, such as to see who can touch the toes without bending the knees, or simple arm-and-wrist movements; various things can be devised which will benefit the health and cheer the spirit and make one and all forget the rainy or the inclement weather.

Music and dancing, or games, may be started, and a true spirit of fun and frolic indulged in. Do not be afraid to play when you play. Unbend and be as little children once in a while. A good charge nurse can even allow a little boisterousness to go on under her supervision, without relaxing the necessary discipline of her ward, for she knows that a play spell is as necessary and as health-producing as food, and much more so than medicine. But do not let the patients feel that they are health-seeking in these things. Let them play for play's sake; thus will they get the truest benefit.

Hunt for the humorous side of things. Laugh *with* your patients, and you will bind them to you; laugh *at* them, and you will estrange them every time.

Some of you may argue, "We are too busy with our ward work to find time to think of these things, much less to carry them out." Do you waste no time in idle talk, in profitless thinking, in selfish ends, in idly sitting about, and in novel reading (and not good novels at that) when on duty, and supposed to be exerting yourselves for the good of your patients? If you

can honestly say "no" to this, and still complain that you have no time for these things, then I withdraw my suggestions; but until you can, I earnestly urge you to consider them.

Set your brains to work in some of the directions suggested — those that seem most applicable to you in your individual fields — and you will be surprised at your own ingenuity in devising means for other occupation and diversion. There are always some patients in your service that you can enlist in your projects. They may even carry them out, aided simply by your timely suggestions, while you are left free to work at other things. Start the ball rolling yourself, and they will often do the rest. Perhaps you will find only a handful at first to second your efforts. Do not be discouraged at this. Form a circle or a group of the acquiescent few, and little by little you will find others joining in, as their interests are awakened. Some who even scoff at first will later remain to play.

An evening on the ward can occasionally be very pleasantly spent in playing school, having primary classes, classes in arithmetic, geography, reading, and spelling, and carrying it all out with a happy mixture of earnestness and fun that will send every one to bed feeling enlivened and rejuvenated to a surprising degree. Be careful to suit your questions and your plans to the individual patients as far as possible: ask easy questions of the backward or the illiterate ones, and take pains not to displease the irascible. Spelling matches and "spelling down" may awaken a very lively interest among patients and nurses as well.

Energy and determination will do much to overcome the indifference and dullness and stubbornness of your charges. The various means, though not always obvious, are not past finding out, and the most signal success will be achieved by the one who ignores the discouraging features in the situation and resolutely says to herself, "I will find a way, or make one."

Never falter, if, after making vigorous efforts at rousing your patients, they lapse back into self-feeling and depression, and manifest delusions which you thought perhaps were being held in abeyance during the diversion. Each time you succeed in taking a patient out of herself you are starting up healthier

brain impressions, and the renewal of these from time to time makes for health and sanity.

You can sometimes get a depressed and agitated patient to smile at the absurdity of, for example, hearing grown people recite: —

“Little drops of water,  
Little grains of sand,  
Make the mighty ocean,  
And the pleasant land”;

and then, as though ashamed of the temporary abandonment of her sadness, she may take up her lamentations with renewed vigor. But the momentary breaking through of that mental attitude has been salutary. Do not lose sight of the truth in the little drops of water rhyme when thinking of the rhyme itself.

I have known a patient who believed it was her duty to sit on the floor by the hour and call through a crack in the door to imaginary people outside to carry out her numerous orders for saving the world, to be taken out for a carriage drive so against her will that it took two nurses to put and hold her in the carriage, and yet after driving awhile get so interested in the world around her as to abandon entirely the giving of orders, and talk with intelligent delight of all that she saw and heard. Just as she was about to return to the ward, she said remorsefully, “Oh, there! I’ve been enjoying all this, *and forgot to save the world!*” It is just this forgetting on their part that you want to bring about often and often, and as a little water wears away a stone, the new and healthy impressions will become a part of their mentality, and perchance restoration to a normal mentality will follow.

If Krafft-Ebing, the brilliant psychiatrist and gifted physician, could spend entire afternoons in the garden with restless patients, if he could give his valuable time to play to them evenings on the piano, is it not incumbent on you, as nurses whose sole duty in this field is the welfare of your charges, to marshal whatever resources you have at command and use them for the good of your patients?

## CHAPTER XVII

### SLEEP AND THE CONDITIONS WHICH FAVOR IT: DUTIES OF THE NIGHT NURSE

SLEEP is a state of more or less complete unconsciousness which admits of needed rest to the brain, but allows the nutrition of the body to continue. All animals and all organs must have periods of rest to counterbalance periods of activity; repose must succeed action in muscle and gland; between each breath the respiratory apparatus enjoys a brief pause; even the heart rests between beats. These periods of rest in the various tissues and organs are recuperative or building-up periods, and in none of the organs are such periods more important than in the brain.

The modern tendency is to regard sleep almost as an instinct, since it comes to us without our having been taught it, and without our realizing the purpose it serves. To regard it so, and to provide for its regular recurrence as one of the vital functions, is conducive to securing it in sufficient quantities to meet our needs.

In sleep we are unconscious; the unconsciousness is brought about by a lessened activity in the cells of the brain cortex. We breathe more slowly and deeply when asleep than when awake, and the secretions are diminished in amount; for example, the tears: when we get sleepy the eyes feel dry, consequently, on waking, the natural thing is to rub them. The pulse rate is decreased during sleep, and the output of carbon dioxide is decreased also. It is probable that the blood vessels dilate during sleep, thus receiving more blood, while a smaller amount than usual flows to the brain. Aside from the above-mentioned accompaniments of sleep, the bodily activities go on much the same as in the waking state. It is chiefly the brain cortex that sleeps while the other organs are awake. The brain cortex

does not fall asleep all at once. Sleep creeps over one gradually; the power to make voluntary movements is lost first, and last, the power to hear things, while just the reverse is true on waking.

In *dreams* the brain cortex is not entirely at rest as it is in dreamless sleep, but, the judgment being in abeyance, all sorts of incongruous ideas may be presented to the mind without being rejected as incongruous.

*Somnambulism* and *dreams* are both differing degrees of sleep. In dreams, as we have said, the forebrain is still partly active, but since the power of judging is in abeyance, and the power of voluntary movement is lost, we may seem to be in all sorts of distressing predicaments, and we suffer real discomfort from inability to extricate ourselves from these supposed conditions. We all know how it feels in nightmare to want to move and to be unable to do so. In somnambulism the forebrain is less inactive than it is in dreams. It retains the power to excite reflex actions, although the *sensorium* is still asleep. In this condition the person can execute many ordinary movements, can walk and talk and carry on a conversation, yet is incapable of distinguishing between external impressions and ideas or memories. This is why, in the somnambulism due to hypnotism, ideas presented to the mind by another seem like realities — why, for example, if the hypnotist says to one in a somnambulic state, “There is a scythe, go and mow that grass,” the duped subject will go and lift an imaginary scythe and mow imaginary grass, much to the amusement of the on-lookers.

Persons differ greatly in the amount of sleep needed, the differences being dependent upon age, temperament, the demands made upon the brain, the occupation, the race, and the climate. On an average, an infant needs from fourteen to sixteen hours, children need from ten to twelve, adults about eight hours, and elderly persons about six.

When one wakens tired, it is a danger signal that nature has not done her recuperative work well. From refreshing sleep to insufficient sleep, or almost no sleep at all, one goes by varying stages, according to the conditions giving rise to these disturbances.

*Insomnia* is the condition of insufficient or restless sleep or



entire absence of sleep. This is one of the most common symptoms in the beginning of nervous and mental disorders. And, strange to say, in many cases the more the patient needs sleep, the less need he feels for it. His brain is overactive, and he resorts to all sorts of things at night rather than cease his activities and let Nature bring her restorative processes to his aid. His tendency is to carry activity to the fatigue point, and the evil effects are seen in lack of poise, unstable emotional conditions, and later in graver nervous and nutritional disorders.

Many neurasthenic patients have such unrefreshing sleep that they think and assert that they have not slept for weeks, but it is an established fact that one cannot go longer than three weeks without sleep any more than he can without food, and few persons probably go that length of time. Insomnia often gets to be a habit just because of unwise ways of living and of regulating one's life. Persons with a hereditary tendency to insanity are especially prone to develop the habit of insomnia. In anemic conditions, patients are often sleepy during the day and wide awake at night. Insomnia may be due to other circulatory disturbances, heart disease, hardened arteries; to toxic conditions, such as poisoning by lead, malaria, drugs, stimulants, or to autotoxic states, as in gout and uremia.

The nightly restlessness and the insomnia of aged patients are symptoms due to senile changes in the blood vessels, and annoying as they are, should be dealt with patiently, since the manifestations growing out of these conditions are things for which the patients are in no way responsible. Such persons need to be soothed and appeased as one would a tired, restless child. Massage is often helpful in these cases.

Strong tea and coffee taken at night are responsible for the overactivity in the thoughts that prevent many persons from dropping off to sleep.

The victims of morphia and of other drugs are proverbially troubled with insomnia. They want to turn the night into day, and the day into night. Hydriatric measures and massage will do much to alleviate this insomnia. Sometimes sponging with warm water to which vinegar has been added proves soothing.

In all cases of sleeplessness or of deficient or unrefreshing

sleep we must search for the cause, which is likely to be a different one in each person. After having made all preparations for sleep that would naturally favor it, if it still refuses to come, one needs to search into individual conditions to find what is preventing it. And it is only fair to say that in some cases, in spite of persistent efforts, certain patients will continue to be wakeful and restless. But these cases should be reported *at the time*, shifting the responsibility on the physician; do not wait till he learns it the next morning on the night report. Some patients who habitually waken at 3 or 4 A.M. will, if given a cup of hot milk, soon drop off to sleep again.

We favor sleep by certain preparations for it, by accustoming ourselves to go to bed at a certain hour, by removing constrictions from the body, by darkening the room, by lessening all possible noises, by securing fresh air in the room, by relaxing the muscles, by closing the eyes and withdrawing the thoughts from the day's activities, or from plans for the future, and by breathing slowly and deeply, and waiting tranquilly for the drowsy feeling to overtake us. Light and noise are potent agents in keeping away sleep, as the various stimuli they arouse affect in turn the would-be sleeper. Monotonous sounds, however, such as the ticking of a not too insistent clock, the droning voice of a reader or speaker, the hum of bees, and the sound of ocean waves, are often conducive to sleep; monotonous passes, or stroking of the brow or of the arms, and swaying of the body, as in rocking, are well-known aids in some instances.

We have said that sleep is as necessary to the brain as rest is to the muscles, but it is also true that exercise is as necessary to the brain as is rest; some cases of nervous restlessness resulting in insomnia may really be due to the fact that the brain has been too sluggish, that it has not exercised itself enough to earn the right to sleep, although the cases of insomnia due to this cause are probably comparatively few in number.

To bring about refreshing sleep it is necessary to undress the body and undress the mind; to remove the traces of the day's soil from the face and hands, at least, and the traces of the day's cares from the soul; to brush the hair and arrange it in such a way that it will not interfere with an easy position of the head,

and to brush from one's thoughts the things that annoy, by refusing to let them occupy the center of consciousness. The extremities should be warm and the head cool, the bowels and bladder should be emptied, but not necessarily the stomach. It is difficult to get to sleep on "an empty stomach," or at least when the stomach has been empty so long that gnawing and hunger are felt. At the same time an overloaded stomach is not conducive to refreshing sleep, although that condition makes one sleepy. With these preparations and a well-ventilated, quiet, darkened room, a comfortable bed, neither too much nor too little clothing, and not too high a pillow, the conditions are favorable for sleep.

When we speak of undressing the mind, we mean to lay aside cares, to withdraw interest from the external world, and so allow the higher brain centers to become inactive. To this end it is not well to prolong one's work up to the hour of retiring. There should be an interval of brief recreation, at least, between work and sleep. If one's work is sedentary, a brief walk or some muscular activity is desirable; especially if it is mental, is it necessary to "shut up shop" and relax and play in some way before sleep is sought.

It is a great mistake to select interesting and stimulating reading in the late evening hours, since, as has been suggested, this is the time when efforts should be made to withdraw everything that tends to brain activity. Those who are given to hard muscular work during the day seldom have difficulty in wooing sleep.

It is important what position one assumes in bed. In the first place, one should be sufficiently but not too warmly covered. Warmth and lightness are the desirable qualities in bed coverings. The bedding should be so arranged at the foot of the bed that it does not draw over the toes. Then there should be complete relaxation of the body. Some persons have the habit of lying with the arms above the head — a habit which should be broken, as should also that of lying on the back. Lying on the abdomen, with the face resting on the arms, for a brief rest, is not a bad position, but the most favorable one for prolonged sleep is to lie on one side, with the head only slightly raised on a pillow,

with the face so turned up as to free the cheek from the pillow's pressure, and so that the full face is exposed to the air; the arms and legs and even the fingers should be as completely relaxed and in as comfortable a position as possible. Watch a sleeping infant in the perfect relaxation that it unconsciously enjoys, and you will see the best example of real relaxation. Instead of this letting go that we can see in almost any sleeping child, most of us, unless we are careful, find that we assume positions in bed that keep muscles contracted that we should relax; we clench our hands or set our jaws tightly together, or hold ourselves on the bed instead of giving our bodies up to the bed and letting it hold us. When we find that this is the case, we need systematically and persistently to cultivate the habit of letting go, to direct our thoughts to securing muscular repose and slow and deep breathing, and we will be surprised to see how these very measures will help us to brush aside the thoughts and cares that have been chasing sleep away. On no account should one cover the head with the bed clothing. This is a habit among a certain class of insane patients that should be broken up by patience and persistence on the part of the nurse.

**Night Nursing.**—The position of night nurse is one of the most important in the entire nursing service. Such nurses are put on their honor, and are intrusted with graver responsibilities than are any of their associates. Such a trust will always make a conscientious person more than ordinarily careful to be alert at every turn, to bring to bear his best judgment, to summon all the resources at his command, to the end that these duties intrusted to him shall be fulfilled in a satisfactory and competent manner.

*Coöperation between day and night nurses* is especially important, and the friendliest coöperation. The utmost pains should be taken by both forces to make the work of each as easy as possible; to see that each is regularly and fully informed of all that has to do with the understanding and the discharge of the other's duties. Sufficient supplies of bed linen and clothing, of medicines, etc., should be left for the night nurse, who should, on the other hand, exercise the utmost care to prevent patients from soiling their beds or clothing, by timely care and attention



to getting them up as often as necessary, for individual cases, during the night. One can to a great extent gauge the supervision of the night nurse in this respect, by the number of sheets found soiled in her department in the morning, especially if they are greatly in excess of those used by the same patients during the day. The care of the mattress and the pillows is especially important, and the nurse who takes pride in preserving these dry and clean, by keeping the rubber sheets in place, and changing her patients as often as they need it, and always washing and carefully drying them when they need changing, is usually one who takes pains to break up uncleanly habits by getting the patients up frequently, if need be, rather than let them habitually soil the bed. In all these ministrations it is important that the work be carried on as quietly as possible. It is not permissible to turn on all the lights to bring this about; no more lights should be used than are absolutely necessary to do the work. The general night watch, who visits the dormitories and rooms every hour of the night, needs to attend carefully to patients needing attention of any kind — a drink of water, a glass of milk, hot-water bag, etc., and to empty regularly any vessel containing fecal matter. The day nurses should take especial care to report to the night nurse transfers and admissions, with the full names and the significant facts concerning them, whether suicidal, or dangerous to others, mischievous, unclean, or ill; with directions as to nourishment, medicines, or special nursing; what observations the physicians are especially concerned about. In short, the harmony and spirit of helpfulness between the day and night assistants should be so close that it amounts practically to continuous observation. There should be no such excuse offered as, "I don't know; the night charge left no account of what happened," or "I received no instructions about the case from the day nurse, and had to do the best I could," and the like. New cases of illness arising during the day or night, with full particulars as to the symptoms and the nursing, assaults, accidents, bruises, special events of any kind — all should be fully talked over by the day nurse in turning her ward over to the night charge, and by the night nurse in turning her ward over to the day charge. It is not enough that the night nurse report



the events and conditions on the blanks furnished for the purpose; these of necessity are limited as to space, and the nurses can go into necessary details in a verbal report that will enable the one who talks with the physician or supervisor to give information that could not always be put on the night reports.

*Night reports*, however, should be just as fully and neatly and legibly made out as possible, and in case of any affair of serious moment, if the blank does not furnish sufficient space for its recording, in addition to her verbal report to the day charge, the night nurse should write out for the physician an account on a separate paper, always dating and signing the paper, which is to show the ward location also. The night reports now in use in the State hospitals call for a list of patients, with spaces to be filled out each hour from 8 P.M. to 6 A.M., stating whether the patients were asleep or awake, restless, noisy, violent, whether wet or soiled, whether they have had convulsions, or have vomited, and so on. Under the heading of special incidents you can put accounts of other conditions not provided for by the key of letters at the head of each night report. The other things called for by the report, the admissions, transfers, deaths, details concerning destructive patients, the ward temperature at the hours specified, all should be conscientiously and properly filled out.

Night nurses are expected to leave the hospitals in order, all soiled patients cleaned, dried, and changed, all vessels emptied, the beds of the patients who have arisen properly aired, the room well ventilated, and the dishes that have been used throughout the night clean.

The night nurse should see to it that she is as quiet and unobtrusive in dress and movement at all times when on duty as it is possible for her to be — in voice, in step, in the moving of dishes or furniture, in the rattling of keys, in the running of water, in the use of lights, and even in the turning of the leaves of a book or a magazine. She should avoid reading newspapers when on night duty, as these cannot be turned quietly. In all her ministrations to waking patients she needs to keep constantly in mind the effort to reduce all noise or disturbance of any kind to a minimum, to the end that others not awake may not be dis-

turbed, and that those who are wakeful and restless may be quieted so that sleep may come to them also. Gowns and aprons too stiffly starched, and squeaking shoes are especially to be avoided. Felt shoes are greatly to be preferred by night nurses, or at least soft, quiet shoes, with rubber heels. Keys should be inserted in locks quietly, drawers and medicine closets, doors and windows opened with the least possible noise, and when it is necessary to speak to wakeful patients, it should be done in a low, soothing, tactful way, bearing in mind continually that the nurse can do much, in time, by the influence of her own gentle example, even with disturbed patients, to bring about a quiet ward, and a habit of consideration for others in those who themselves cannot sleep. It is inexcusable to scold or threaten troublesome patients; it not only defeats the purpose of securing a quiet ward, but is a thing that will not be tolerated by the hospital authorities, and is beneath the dignity of any one aspiring to be a nurse.

The heating and the ventilation of the wards at night are especially important, and it is largely owing to the nurse's efficiency in regulating these matters that the restful sleep of many of her patients is due. She should be so warmly clad herself that she can be comfortable in the prescribed nightly temperature of the wards, and not expect to keep the rooms so warm that she, sitting around in a thin gown, will be warm as toast, while her patients are too warm to sleep.

A competent night nurse will not suffer patients under her care to be noisy, disturbed, and wakeful without constantly exerting herself to seek the cause of such disturbance, remedy it if possible, and report such conditions if she cannot, so that other measures may be taken for their relief.

Wakeful patients may often be soothed into a restful sleep by very simple measures on the part of the nurse. New patients can be comforted and reassured, hungry ones fed, untidy ones made tidy, disturbed ones appeased by some little suggestion or diversion, quarrelsome ones separated, restless ones made less restless by attention to the regulation of the temperature, the bedding, whether too much or too little, by an evacuation of the bladder or of the bowels, by a drink of water, a slice of bread and

butter, by a glass of hot milk, by a cold compress on the forehead or around the wrists, by a hot-water bag to the feet if they are cold, or to any part in pain, by soothing stroking of the brow and limbs, bathing hands and face in alcohol and water, warm or cool sponging of the spine, or rubbing of the back (avoiding talking meanwhile), by baths or packs if ordered by the physician, and in countless other thoughtful ways that will suggest themselves to the conscientious, alert, resourceful night nurse.

Sometimes going to a wakeful patient and sitting by the side of, but not on, the bed, talking to her in a low tone, or letting her talk for a little while, will allay the nervous restlessness that is preventing sleep, especially if there are troublesome thoughts from which she needs to be diverted. Stroking the temples or pressing the fingers on the eyeballs, with a quiet command to sleep, will prove helpful to some patients. In all stroking movements avoid talking or unnecessary movement.

Narcotics are never to be administered except on the order of a physician, and on no account are medicines prescribed for one patient to be given to another unless so ordered. Patients are never to be wakened to administer medicine to them unless so specified by the physician. Especial care needs to be exercised at night, because of the subdued light, in reading the directions and administering medicines exactly as they are prescribed.

If a patient's wakefulness is due to pain, the nurse should do all in her power to ascertain the seat of the pain, and its cause, if possible; whether from headache, toothache, indigestion, hunger, menstrual cramps, diarrhea, etc. She should make sure that the bed is as comfortable as possible, dry and clean, free from wrinkles and crumbs, that the eyes are shaded from the night light, that no flapping window shades, rattling windows, defective traps, dripping water faucets, creaking doors, or any unnecessary noise is helping to keep the patient awake. At the lunch hour the nurses should be particularly careful not to waken patients by their talk, or by the rattling of dishes. Inconsiderateness in this respect is inexcusable. Weak and aged patients, and those especially susceptible to draughts, should be given as protected places in the room as possible, and with those patients who object to the necessary ventilation, especial

pains should be taken to appease them and allay their fears and objections rather than to antagonize them. This can often be done by explaining to them that you will see that they shall not take cold, but that in a room with so many persons, or even in any sleeping room, it is necessary that an abundance of fresh air comes in at night, so that sleep will be more refreshing, and that their bodies will be built up while they are sleeping. If you go about it in the right spirit, you will be surprised to see how many patients you can persuade to listen to reason, but if you ignore their complaints, or brusquely reply to them, you can hardly expect amiability and docility on their part.

Patients with visual hallucinations and illusions should not be in a room entirely dark at night, as these symptoms are more vivid in a dark room and at night than under other conditions. This applies especially to alcoholic cases, *e.g.* delirium tremens.

The night nurse has exceptional advantages for the observation of her patients, since the many distractions of the day are absent. She can often note and describe attitudes and habits, the character of the delusions, the stream of talk, the character of the sleep, whether quiet or disturbed, whether there is starting in the sleep, or talking, or troublesome dreams, any unusual positions of the body, whether the patient is very easily awakened, what his condition seems to be on waking, etc. Patients who waken in a frightened condition, often with the fears left from a troublesome dream still remaining with them, should receive especial care from the nurse to divert and quiet them. Epileptics need especial watching, from the beginning of the convulsion till stupor supervenes. The nurse should never grow so callous to these occurrences that she fails to observe the patient closely during the convulsion, and to render what aid she can.

The nurse needs to remember that in the early morning hours, from 1 to 4 A.M., the vital powers are at the lowest ebb, and that her feeble charges need especial care at those times — more heat, more coverings, hot-water bags to feet, hot milk to drink, but not less air.

If the nurse has difficulty in keeping awake, and there is absolutely no patient to whom she can minister, since all are



sleeping, or at least quiet, she can practice counting the pulse or the respirations of such patients as will not be disturbed by such a procedure, and so be acquiring more proficiency in this direction, at the same time that she guards herself from a grave infringement of the rules; to sleep on duty is a grave misdemeanor in a night nurse for the insane; the position is one of great responsibility, constant watchfulness is needed to guard against accidents of various kinds, against assaults upon others, against suicides, to say nothing of the supervision necessary to prevent the destruction of property, and to guard against and to break up habits of uncleanness. A night nurse who fails to take her proper amount of sleep in the daytime, and who puts in that time in work or play when she should be asleep, is not acting honorably with the institution for which she works, for she is thereby unfitting herself for the proper discharge of her duties, and even with the best intentions to keep awake, she is in danger of succumbing to the demands of cheated nature. When she does this, even if she is not discovered, her work cannot fail to deteriorate, and her own self-respect to diminish. Since so much is intrusted to her, it is highly important that she preserve her health by plenty of sleep, good food, and daily exercise, and that she bring to her work each night a sympathetic interest in her various charges, an intelligent understanding of their needs, and a ready intent to help them in every way that lies in her power.

The means for fire protection, the hose closets, the regularly filled bath tubs for a ready supply of water in case of emergency, the care of matches and of lanterns, the safeguarding of medicines and disinfectants, and of all appliances or contrivances whereby patients could harm themselves or others — attention to these also constitutes a part of the exacting duties of night nurses.

A few words are necessary about the early morning hours on the wards. Many patients waken early, and unless prevented, wish to get up and dress. It is also a fact that the night nurse has many duties to attend to in order to leave the patients and the ward in proper condition for the day nurses, and after the long hours of the night she welcomes the stir and bustle of the morning that show that her long vigil is nearing an end. But



here she needs to remember how very important it is to her patients that they be allowed to sleep as late as possible, and that all her necessary activities be carried on as quietly as possible so that no patients be cut short of the all too small allowance of sleep accorded them. Patients who tend to waken too early should be required to remain in bed until the time for rising arrives, and even then, if others are sleeping, or would sleep if the ward were quieter, the conscientious nurse will use every effort in her power to secure them this additional sleep. When you rob a nervous or mental patient of sleep, you are retarding if not seriously prejudicing his chances of recovery, while in chronic cases you are fostering conditions that increase discomfort and exaggerate nervous excitability.

We can perhaps sum up briefly the duties of this position by saying that they consist in maintaining a vigilance that never sleeps, but that is quietly observant in ascertaining and prompt in applying measures for promoting sleep in the patients.

## CHAPTER XVIII

### A TALK ON PSYCHOLOGY

*Psychology* is the science of mental life. It deals with all manifestations of the mind, such as feelings, desires, reasonings, decisions. In order to experience any of these phenomena, we need first to receive impressions through our sense organs and to have them registered in our brains. On the other hand, various mental states that we experience occasion bodily alterations, such as changes in the caliber of the blood vessels, in the rapidity of the heart beats, and in the secretions of the various organs and glands. We thus see how body and brain act and react upon each other, and cannot therefore be considered separately.

We are, in reality, the sum of all that we have seen, heard, smelled, tasted, and felt since our conscious life began, *plus* our inheritances from all the lives that have preceded ours as our progenitors, and *plus* the results of our response to all that we have experienced. I shall try to make plain farther on why this is true.

Many of our acts which are apparently performed unconsciously were originally the result of conscious effort, but have been performed so often that the habit of doing them has resulted, and in time we come to do them more or less automatically. Standing, walking, dressing and undressing, writing, speaking, piano playing, knitting — these are but a few of the many *automatic acts* of everyday life.

Inanimate objects, that is, things without life, can perform no intelligent act; but living beings, in proportion to their development, possess the power to reach certain ends by varying their conduct to suit the conditions and obstacles that confront them. Professor James illustrates this difference very forcibly when he

speaks of how iron filings behave when a magnet is brought near them, how they will even fly through the air for a certain distance and cling to the magnet, but how, if a cardboard be placed over the pole of the magnet, the filings will stick to that card forever, without knowing enough to pass around the card and get in contact with the magnet that is attracting them. But Romeo and Juliet, as he points out, while drawn to each other as the filings are drawn to the magnet, learn to move in circuitous lines if obstacles to straight ones are raised, learn to scale walls and find each other in spite of opposition and difficulties — all because they are capable of *conscious intelligent acts*. The movement of the filings toward the magnet is a *mechanical act*, the progress of Romeo toward Juliet is an intelligent one (although not exactly a wise one, as the resulting tragedy proves). In a lesser degree than Romeo's aggressive actions, the acts of the lower order of animals are intelligent in so far as they are performed *for the sake of* their result, although many of these seemingly intelligent acts are the result of inherited instincts, and are consequently more or less automatically performed. We see this same *automatic intelligence* in certain plants as well as in animals — creeping vines lifting themselves to the rough surface of a wall to which they can cling for support, or a potato sprout sending out its long arm to reach the light and air. These, of course, cannot be called intelligent acts in a psychological sense. Only, then, such acts as are done with a conscious end in view, and show that choice has been made in the means employed, are properly called *intelligent acts*, and only beings capable of intelligent acts may be said to have *mind*.

The brain is the organ of the mind; it is material, while the mind is immaterial. In other words, the brain has a certain structure made up of matter, while mind is something we cannot see or appreciate by any of our senses; it can only be known to us through its operations — through evidence within ourselves, and to some extent through our observations of its operations in others. What we learn of its workings in others is learned *objectively*; what we learn by studying our own minds during and after operation, by self-analysis, or *introspection*, is learned *subjectively*.

Mind shows itself by means of its three faculties: thinking,

feeling, and acting. These mental processes are accompanied by certain activities in the nervous system, and the degree of mental activity is curiously dependent upon the disposable energy of the brain, while the brain is dependent upon the condition of the nervous system as a whole; so that disease, fatigue from severe brain work, or loss of sleep, or exhausting emotions, affect the power of work of the brain, and so affect the workings of the mind.

The kingdom of nature is divided into three great classes, mineral, vegetable, and animal, to go from the lowest to the highest. There is an old statement as follows: "Stones grow; plants grow and live; animals grow, live, and feel." This gives us broadly the degrees of difference to be met in the three kingdoms. Stones grow by the process of accretion — an adding on of material from without, although they belong to the inanimate part of nature; plants grow and live because they have what we call the *vegetative functions* — they have the power of inherent motion, they can appropriate nourishment from their surroundings; their life is carried on by the processes of absorption, circulation, respiration, and reproduction; but animals feel as well as grow and live, and this because they have a nervous system; in some, of a very rudimentary sort, in the higher orders of a very complex structure. Pluck a rose from a bush, and the other roses go on blooming, all unconscious that a part has been severed from the whole; but bruise merely the finger of a man, and every part of his body seems aware of the violence done him. This awareness is brought about by the nervous system, which brings all parts of the body into relation with one another. Nerves which are stimulated by the bruise convey the excitement to the nervous centers, the commotion thus set up there discharges itself through another set of nerves into muscles which move the limb in a protective way in order to get it away from the thing that is bruising the finger. When the response of a part takes place without the intervention of the will, we call the act a *reflex act*; when it is a result of a consciousness of the purpose to be attained and a command of the will, it is *voluntary*. Many reflex and voluntary acts become merged into each other, and are called *semi-reflex acts*.

The lower centers of the nervous system act in response to whatever excites them at the present time, while the higher centers, which are believed to be the seat of memory, act from groups of former sensations received and from considerations concerning these former sensations, with a weighing of the probable results of a contemplated act.

Victor Hugo's hero, Jean Valjean, well illustrates in one individual these two extremes. Early in his career, in a moment of sudden temptation, he gives way to the animal desire for food for himself and seven little children dependent upon him. He steals a loaf of bread, is caught in the act, sent to the galleys, and suffers a long train of tortures and misery as a result of his theft. Later, when he has worked out his long sentence and is free, but with the stigma of a convict still upon him, he is befriended by a good bishop who gives him shelter and trusts him with the freedom of the house, in which is kept a lot of costly silver plate. He awakens in the night and thinks of his sore needs, of how much money the silver would bring him; he undergoes a terrible temptation, torn between his desire to be worthy of the trust the bishop places in him and his need of the money. He does not quickly yield to the temptation as he did in the beginning of his career; memory recalls to him the long train of consequences of that first theft; his partly awakened moral nature makes him aware of the baseness of his contemplated deed, but as yet the lower centers are more in the habit of being used than the higher ones, and so the impulse to act follows the path that is well worn in the nervous system, instead of the unaccustomed higher one. Jean Valjean steals the silver plate from his benefactor, and soon finds himself again in wretchedness as a result. We cannot here trace his career, but a study of that wonderful novel of Hugo's, *Les Misérables*, will show you how the man's higher centers gradually assumed control over the lower, how he was gradually able to withstand temptations which he first yielded to, how resistance strengthened him in well-doing, and how the ennobling effects of self-discipline and of doing good to others made him stronger and stronger, going on from victory to victory, till one can hardly recognize the desperate criminal of the beginning of the story as the redeemed



and regenerated hero at the end. The reconstruction of the character was a slow and painful process. It was brought about by the creation of new and right paths in the nervous system; by suppressing lower impulses and harkening to the higher ones; by overcoming evil with good.

Our whole life is made up of two classes of things — impressions and movements — impressions made upon the nervous system, and movements resulting from these impressions. It can then be easily seen how important it is that we put ourselves in the way of receiving as many favorable and helpful impressions as possible, and, on the other hand, how supremely important it is that we react *in the right way* to whatever impressions come, refusing to be dominated by those that would lead to ignoble acts, and taking advantage of all that stimulate to noble ones.

We have previously spoken of the *faculties of the mind* as thinking, feeling, and acting. In order to *think* about an object, it first has to be sensed, perceived, remembered, and reasoned about. In order to *feel* what is implied in the words sorrow, joy, fear, anger, jealousy, love, a pleasurable or painful state of mind, an *emotion*, is experienced. In order to *act*, we deliberate upon what we have already thought and experienced, and we decide to do or to refrain from doing a given thing.

We need to be here reminded that the nervous system is made up of nerves and nerve centers; that the nerves are of two kinds, the *sensory* or in-carrying nerves, which convey impressions received by the sense organs to the nerve centers; and the *motor* or out-carrying nerves, which convey the impulses that cause the muscles to respond to the impressions that have been received; the nerve centers themselves consist of sensory centers which receive excitation from without, and motor centers which excite the out-carrying nerves.

There is a great difference in individual minds in their susceptibility to impressions, in their power of attention to them, in their ability to compare and discriminate between various impressions, in their emotional susceptibility, and in their manner of responding to received impressions. There is also a great difference in any one mind under varying conditions.

In order to know anything about the simplest object, certain successive stages have to be traversed. Through some one of the five senses an impression of that object has to be conveyed to the mind. This we call a *sensation*. This sensation is followed by an awareness of the object, a conscious attention to it, which is called *perception*. This is a much more complex process than sensation, as it necessitates the grouping together of previously received sensations, regarding them in their various relations, and apprehending them as immediately present outward realities. After perception comes the image-making in the mind of what the mind has perceived — the *imagination*. Finally we have the *thought* or *knowledge* about the object. This consists in forming general notions about what we have already perceived and pictured (*conceptions*), of forming opinions and coming to conclusions about it (*judgment*), and of, perhaps, combining these opinions and forming opinions about similar objects (*reasoning*), since what we learn of one object gives us a clew as to what we may reasonably infer about a similar object.

Upon the keenness of the perceptions, the retentive power, or the ability to store up and revive the products of former impressions, and the ability to utilize them in the thought life, depends the efficacy of the individual so far as his intellect is concerned. Brain power is increased through exercise in two ways: in some way that we do not understand, all brain activity reacts upon the particular structure engaged, modifying it so that it is disposed to act in a similar manner again; then there is a tendency for different parts of the brain which are exercised together to fall more and more readily into this coöperative action. This is what is meant by paths being formed in the nervous system, along which impressions and impulses flow more and more readily as they become worn by use.

By *attention* we mean the active interest that the mind takes in a given thing at the moment it is being regarded. The *power of attention* differs greatly in different persons and in the same person at different times. We have to attend in a general way to a great many things at once, and all the things that are receiving attention from us at a given moment make up our *consciousness* at that moment. Some are more sharply per-

ceived than others, because on them we concentrate our attention. Some things, we say, we regard *subconsciously*; that is, they occupy the outer rim of our consciousness instead of the center of it, just as when we glance at any one object we see that especial object with distinctness, surrounding objects with less distinctness, and objects farther removed from it with still less and less distinctness. So in our consciousness we speak of the things that occupy our immediate attention, and others of which we are clearly aware, even though regarding them less intently, as being parts of our *conscious life*, and those that occupy the outer rim of our mental field of visions, which are but dimly perceived and attended to, as being parts of our *subconscious life*. This closeness or vagueness of attention applies to our sensations, to our intellectual activities, to our emotional life, and to our actions. We are continually bringing some things into the center of our mental field of vision and crowding others farther and farther out toward the rim; things are being shifted about as are the colored pieces of glass in a kaleidoscope, our voluntary attention answering to the hand that turns the instrument. The things we see, or sense in any other way, have their direct influence upon us, then, in proportion as we heed them; the pleasures and the pains we experience take hold of us according as we fix our thoughts on them, or disregard them; the kindnesses of others, or the slights or injuries that we receive at their hands, affect us in so far as we look attentively at them, or look away from them; even our diseases, many of them, are capable of being pushed to one side, or of being the closest of companions, according to our manner of attending to them.

We have previously learned that a *sensation* is a mental state resulting from the stimulation of the outer extremity of a sensory nerve. This stimulation or excitation has to be conveyed to the sensory center in the brain before the mind experiences the sensation. If the connection between the nerve extremity and the center is broken, no sensation can result. It takes a certain appreciable time for the transmission of the stimulation to the center and for its effect to be noted in whatever reaction takes place, although the reaction ordinarily seems instantaneous. Numerous experiments to determine the length

of time it takes for a muscular reaction to result, after a sensory impression has been made, have shown that this *reaction time* varies in different individuals, and with the same individual under different conditions. Aged and uncultivated persons, and children, are slow to respond; practice in the application of any given stimulus brings about a more and more prompt reaction; fatigue lengthens the time, making one "retarded," as we say, while concentration of attention shortens the time, just as distractibility, or a "scatter-brained" way of regarding things, lengthens it.

These reactions have been tested in regard to sound, light, electric-skin reactions, touch sensations, taste and smell reactions, and the like. Sound is more promptly reacted to than either sight or touch; taste and smell are slower than either.

The regions of the skin where the stimuli are applied have much to do with the quickness or slowness of the reactions, the parts most abundantly supplied with nerve terminals being those that yield the speediest results. Intoxicants, coffee, tea, etc., alter the reactions, usually quickening them primarily. This is why brain workers so often resort to these stimulants to help them do their work. The tendency of alcohol is at first to quicken, then to lengthen, time reactions; morphia lengthens them, also ether and chloroform; certain diseased states do also.

By the term *sensibility* we mean the mind's capacity for being acted upon by the stimulation of the sensory nerves.

Psychologists differ greatly in their use of the words *sensation* and *perception*; we cannot enter into these differences here, but will follow those who regard a *sensation* as being the reception in a sensory nerve center of an impression received from the outer extremity of a sensory nerve, while the *perception* of that impression consists in referring it to a given object. For example, a book is held before my eyes, and through the sense of sight I am made aware of its appearance. This appearance, as it is conveyed to the sensory center in my brain, constitutes the sensation; while my perception of it, or, in other words, my ability to project this sensation into the world outside of myself and connect it with the object (the book), is a rather complex process, and is dependent upon my having previously seen other



books, and of learning about them as regards form, color, size, feeling, etc.

By sensation and perception, then, we mean processes in which we become aware of an objective world. If an object has a single striking quality, whether it be detected by the sense of sight, hearing, taste, smell, or touch, we note it as such, and as such we get a sensation of this quality. It may be the color, the odor, the noise; whatever it is, its distinguishing quality determines the force of the sensation. It may be a single sensation we get from a given object, or a combined one. If we feel a hot poker, we get the simple sensation of pain; but if we see a poker under varying conditions, we get from time to time various sensations concerning it; we see not only that at times it may be red-hot or white-hot on the end; we also see that it is long and round, that it has a handle at one extremity, that the handle is of wood, that the remaining portion is of iron; we learn that the wood has a certain feel, the iron another, and all the various sensations we have received concerning it make up what we call a percept of the poker; and the grouping of these sensations, discriminating them from other sensations and referring these groupings to the object itself, we call a *perception* of the poker, which, it can be readily seen, is a much more complex process than any single *sensation* concerning it. The more we know of any object, then, the more keenly aware we are of it in all its qualities, the fuller our perceptions of it become. It is natural for some minds to note one quality of an object keenly and to slight the other qualities; some persons are more alive to form, others to color, and others to still other qualities; and because of these innate tendencies in various minds we get such different results in their reports concerning objects. This is the principle that is at the bottom of so many conflicting statements and half truths about things in life. Each person reports things from his point of view, colored by his own particular way of looking at them; if he have an eye for color and not for form, we get perhaps the truth so far as the color of an object is concerned, but often a very distorted and untruthful representation so far as its form goes, and *vice versa*. If six persons witness an accident in the street, we shall get six very dif-



ferent reports of the occurrence, all representing certain sides of the truth, but no one of them representing the whole truth, because no one saw the whole truth, but only what appealed most to his powers of observation. The real education of our minds, then, consists in training the senses to be keenly alive to all the qualities of objects of study; we need to look all around them, to apprehend them in all their relations; and in proportion to the honesty of our observation, and to our discriminating attention, will we be rewarded with a truthful knowledge concerning them.

Our experience in reality is made up of what we consent to give heed to. It is the interest with which we regard things that makes them enter into our experience and become a part of ourselves. If they slide off, like water off a duck's back, it is for us almost as though they had never been. This is a truth that works for good as well as for ill. By inattention to the everyday beauty of the world around us, and inattention to the moral beauty as well, we render ourselves blind to it; it is as though it did not exist, and yet we are aware of a hundred and one less ennobling things which occupy the center of our consciousness because of the keen attention we give to them. On the other hand, because of our ability to select what things we shall allow to occupy the center of our consciousness, we are enabled to crowd aside to a great degree unworthy objects of attention, moral ugliness, unwholesome stimuli, perverted thoughts, and the like. The old saying, that as one makes his bed so he lies in it, has its counterpart in the literal truth that by the way of attending to things and the kinds of things attended to, each chooses for himself what kind of a world he will live in.

Investigations show that when the cortex of the brain is electrically excited, respiration and circulation are quickened, the blood pressure rises, as a rule, all over the body; the instrument called the sphygmograph shows decided pulse variations during intellectual and emotional activity and repose. The blood supply to the extremities is diminished during intellectual activity; cold hands and feet are the result. When less blood goes to the arms, more goes to the head. Scientists have proven by exquisitely adjusted apparatus applied to patients that so slight a thing as the entrance of a professor in the room has

appreciably altered the blood supply, that the effort to think, that even being spoken to, are all registered by means of mechanical contrivances, all of which goes to prove that there is nothing that we see or hear or feel, or experience in any way, intellectually or emotionally, but affects our bodies correspondingly, and accordingly our minds, since bodies and minds in living human beings cannot be rightly regarded except as parts of one whole. We are prone to lose sight of this fact and to make light of the impressions that are coming to us as healthy individuals, as of little or no importance, or only of passing moment, but it is literally true that we are the sum of all that we experience, and that our surroundings modify our physical and intellectual lives at every turn, leave their emotional imprint, determine our various reactions, and so fashion our characters. If this be true of the healthy body, it is much more so of the diseased one, especially true of patients with nervous and mental disorders, with their exaggerated sensibility. The practical point we need to consider in contemplating this truth is in reducing to a minimum all the unfavorable influences or stimuli, and in increasing to a judicious degree the favorable ones. Noise, contention, disappointments, the irritating effects of too much light, the presence of antagonistic personalities, the application of injurious physical or mental stimuli of whatever kind, must all be avoided in our care of nervous and mental invalids. Excited cases need a lessening of all stimuli, even ordinarily favorable ones; depressed ones need a judicious application of those which will arouse the system to wholesome and normal reactions.

We commonly speak of various *faculties of the mind*, such as perceiving, reasoning, judging; but the more modern way of looking at these things is to regard all these different manifestations of *intelligence* (knowing) as so many different ways in which ideas combine with one another; in other words, they are regarded as images of various sensations associated together. We arrive at the knowledge of the workings of mind largely by looking into our own minds and thinking about what we find there. This looking within is called *introspection*. The things we think of are *cogitations*, and the knowledge thus derived is

*cognition.* What happens when thinking is going on in a mind? Several things happen. The thought tends to become a part of the personal consciousness; the thought is always changing, it is continuous, it always appears to deal with objects independent of itself, and it is interested in some parts of these objects to the exclusion of others, so that it is choosing among them all the while. Since thought is in constant change, our point of view is constantly shifting; we see things in new relations; we see similar things differently under different conditions; we can never have the same state of mind twice; all preceding sensations, thoughts, and experiences modify succeeding ones; we are remolded anew at every moment; and what we feel and think now, at this moment, is a product of all that we have thought and felt before. We look at the face of a friend to-day; it is a different face than we ever saw before. The impression we get is a complex one, not dependent alone upon what we actually see at the moment, but upon all that we have seen before, all that we have felt before, and all that we are feeling now, *plus* all the varied modifications that have taken place in the face itself by reason of our friend's varied experiences — these modifications are all fused into a complex feeling that we lightly speak of as looking at a friend's face. The friend is changing and we are changing; of necessity it follows that we can never see his face twice alike.

Although our state of mind or our consciousness is changing all the time and we are seeing things in new lights and in different relations, so that to an attentive observer the same objects never appear twice the same, still within each personal consciousness the stream of thought is sensibly continuous, and if any temporary interruptions occur in it, that is, if the person becomes momentarily unconscious, either by fainting away, by taking an anesthetic, or in sleep, when the gap in time is bridged over again, the person is aware that there has been a gap; he comes to himself, we say, becomes conscious of his own personality; he awakes, and remembers, and understands. This part of us that is conscious of the fact that all the experiences that have come to us belong together and are inwardly connected, forming a common whole, is what we call the I, the *ego*.

The whole universe is divided into two portions by each creature — the “me,” and the “not-me.” All that comprises the *me*, and that is included in *mine*, is of paramount importance to the individual. No creature, however humble, but exalts the *me*, is interested chiefly in the *me*, in preserving, expressing, and reproducing the *me*; and all the remainder of the universe is grouped in one foreign mass as something outside of the *me*. It is right that this should be so; it is provided for in the inherent nature of things; only so could life be successfully carried on in a world teeming with so many different species, and so many different individuals, struggling for existence.

All that pertains to a man is broadly included in his *me*, in his *self* — not only his body and his mental powers, but his belongings, his home, his family, his ancestors, his reputation, his work, and the like. These things constitute a man’s Self in the widest sense. This Self may be subdivided into separate selves — the material self, the social self, the spiritual self, and the pure Ego. The feelings and emotions that grow out of these selves are called *self-feelings*, and the actions prompted by these self-feelings are *self-seeking* and *self-preservation*. Out of the conditions and needs of the *Material Self* grow the care and preservation of the body, the custom of acquiring things, a home, property, belongings; one’s family is also grouped under this head, as we consider the different members as bone of our bone and flesh of our flesh; what concerns them, if we have the normal feelings toward them, concerning us only a little less intimately. The *Social Self* has to do with man’s relations to his associates. Man is a gregarious animal. He likes to flock with his kind. He likes to be noticed and favorably noticed. He lives up, or down, in a surprising degree, to what his associates think of him; his respect for self naturally increases or diminishes according to the respect in which he is held in the community. If the feelings which make up this social self are exaggerated one way or the other, we get marked manifestations as a result. The person may have an overweening sensitiveness as to what others think of him, and so be swayed far away from his own center, or he may have an alteration of the social instincts and become a recluse, a misanthrope, or even a man hater. The *Spiritual*



*Self* has to do with a man's inner or subjective being, his mental faculties or disposition. This is the most intimate part of ourselves; it is nearer than our bodies, for it is that inner existence of which we are conscious when we sense, perceive, weigh, and decide things and feel that it is the real self within us that is doing it, the Self of selves. It is the part in us that presides over what we are experiencing, and decides what our acts shall be. When this part of us becomes so altered that our subjective life undergoes a radical change, we are said to be alienated from ourselves, or insane. Over all these selves, even the Self of selves that perceives and decides things, is a *consciousness of self*, a *feeling of personal identity* — a feeling that the real *I* exists whether the body is acting or refraining from acting, and this permanent feeling of being one's self constitutes the pure *Ego*.

*Self-feelings* arise out of this complex thing we call Self. They are of two kinds, *self-complacency* and *self-dissatisfaction*. Self-complacency seems made up of self-esteem, pride, vanity, and kindred things, and self-dissatisfaction of humility, modesty, diffidence, shame, contrition, and the like. These two opposite feelings are common to all of us; sometimes one predominates, sometimes the other. They are dependent upon a complexity of things, and are subject to great variations according as we meet with success or failure in our undertakings, and as our bodies are working healthily and harmoniously; and again these opposite feelings play hide and seek with each other, without our being able to say just why first one, then the other, predominates. Each of these states has its characteristic bodily expression. In self-complacency the extensor muscles are in action, the eyes are bright, the nostrils dilate, the mouth is wreathed in a complacent smile, the carriage of head and body is commanding, the gait rolling and elastic, and the voice full and vigorous. In the opposite mood, when it is extreme, the flexor muscles are innervated, the figure is drooping, the head is bowed, the eyes downcast and dull, the voice low, the movements languid, and the whole tendency is to cringe and slink away from notice. Varying degrees of these opposite states of feeling may be observed any day in your acquaintances, or in



chance passers-by, and the more extreme expressions of these self-feelings are before you continually on the wards.

The things that the Self has to accomplish are *self-seeking* and *self-preservation*. Self-seeking may be bodily, social, or spiritual self-seeking. Under bodily self-seeking come eating, drinking, defense, acquisition, homemaking, and the countless things that contribute to our material welfare. Social self-seeking is carried on through amateness, friendliness, a desire to please, love of fame, of influence, etc. Spiritual self-seeking includes every impulse toward psychic progress, whether intellectual, moral, or spiritual in the more narrow sense of the term. It is the reaching out of the creature for all that will elevate and redeem the inward nature.

All these selves are constantly engaged in a sort of rivalry or conflict, and sometimes one has the mastery, sometimes the other. In some persons we get but faint glimpses of anything but the material self, such a hold has the material life on their aims and thoughts and activities; in others the social side of life is the greatest thing to be desired, and these count all else well lost if they compass their heart's desires in the social realm; while the seeker of his truest and deepest self counts the world which is lost to him as of little account if he possess his own soul. The well-rounded individual knows himself, knows that none of these selves can be ignored; that each side of his nature is given him for a wise purpose to help him fulfill his destiny, and to bear the proper relation to other lives that touch his life; but each person needs to examine himself, determine which self-seeking he is to pursue with the greatest earnestness, which aims seem to him the most to be desired; then, steadily pushing on in that direction, make all other efforts subordinate to the chosen ends. This is what makes of a life a success. It may not be a success in the opinion of others with different aims; but, however low the standard, if the individual sets forth to himself clearly *which* self-seeking he most desires to achieve, and in the end achieves it, his life is a success in that direction, so far as his point of view is concerned. If his aims have been what a more spiritual-minded person would call low, if he has eaten of the fat of the land, if he has lived in the life of the senses, if he has been

concerned chiefly in acquiring treasures that moth and rust can corrupt and thieves break through and steal, if he has been possessed with the "mania of owning things," if he has been blind to the physical beauty all about him and to the moral beauty that is exemplified in humble lives that he scarcely deigns to notice, if he has never known the luxury of self-sacrifice, he has nevertheless achieved *his* success; for, to him, the material self was the real one, its triumphs were his only triumphs, its failures his only failures; he reckons it no shame to have failed in the development of the higher and better selves.

Between the extremes of those who make material self-seeking and spiritual self-seeking their aim there are all grades, and in individual natures these various selves are often contending for the supremacy, and so we get all the variations, from the pronounced *egoist* to the most visionary *altruist*; we get the miser on the one hand and the socialist on the other; the fighter, and the one who runs away to fight again (or run) another day; the athlete and the bookworm; the globe-trotter and the hermit; the epicurean and the stoic; the mystic and the scientist; the practical man and the poet; the carnally minded and the spiritually minded; in short, all of the sharp contrasts as well as their intermediate grades, according as each individual sets his standards for himself and decides which of his selves he will cater to, which he shall adopt as expressly his own.

## CHAPTER XIX

### THE POWER OF HABIT

ALL living creatures are bundles of habits. Some habits are the result of innate tendencies called instincts, and some are the result of training and education. Even the elements have habits; all matter behaves after its kind; it follows natural laws, we say; in other words, it obeys certain innate tendencies. These habits are less variable, however, than the habits of animate nature. The way that inanimate matter changes is not in its individual particles, its atoms, which are not subject to change in themselves, but in the rearrangement of its atoms to form new compounds, the rearrangement being brought about either by outward forces or by inward tension, making of the body of atoms a different structure. For example, a bar of iron is rendered magnetic by being brought close to a natural magnet. Its appearance is not thereby changed; the change is wrought inwardly in the molecules, rendering it attractive to iron filings.

Our clothing acquires habits, takes on the creases that are caused by our forms and movements; old locks work easier than new ones; a paper once folded tends to fall into the same creases again.

In a general way, animals of a given species have very similar, almost identical habits, which are the result of their inborn tendencies and handed down from generation to generation; but some of these habits undergo modifications to suit varying conditions.

We say of anything that is capable of gradually yielding to an influence, so that it in time can be modified, that it has *plasticity*. If anything yields too readily to an influence, we speak of it as being unstable; if it undergoes change very slowly,

tenaciously holding to its original structure and habits, we speak of it as stable. And between the extremes there are all gradations of plasticity, and each modification, the effect of outside influence, results in a new set of habits.

Nervous tissue is especially susceptible to influence; in other words, has great plasticity; consequently living beings are capable of being trained to new and still newer sets of habits by virtue of their nervous systems. Just as water hollows for itself a channel which deepens and widens with time, so impressions made upon our nervous systems wear paths that become more and more easily followed as time goes on. And this is true of other bodily structures also; an ankle that has been sprained once yields more readily to succeeding strains; a joint that has been dislocated easily succumbs to a lesser force in the future; a mucous membrane once the seat of inflammatory and catarrhal changes is rendered more susceptible thereafter, so that we acquire, as we say, the habit of taking cold. This habit tendency is seen in many functional nervous conditions; neuralgias, for example, once set going, have a tendency to continue; the pain habit is established, and the patient becomes a victim of the habits of his nerves.

Brain and cord can only receive impressions through the blood and through sensory nerve roots. These two forces deepen old paths or make new ones, and on them depends the plasticity of the brain.

We learn from studying habits that their practice simplifies movements, making them more accurate, and diminishing fatigue; that the more often we practice a habit, the less conscious attention we give to it, doing it automatically.

Professor James points out the beneficent as well as the evil effects of habits, in that the acquiring of them enables us to accomplish most of the necessary acts of daily life with more or less automatism, leaving our higher centers free to work on higher things. He reminds us that habit keeps each one of us fighting out the battle of life upon the lines our inheritance and early choice set for us, and he says that on the whole it is well for the world that in most of us, by the age of thirty, the character has set like plaster, and will never soften again.

It is generally conceded that the ages from childhood to twenty are the most important ones for fixing personal habits, such as those of speaking, gesture, motion, and address, while from twenty to thirty is the critical one for the formation of intellectual and professional habits.

Psychology teaches us the importance of making automatic and habitual, before the age of twenty, if possible, as many useful actions as we can, at the same time that we guard against growing into undesirable habits of life and thought.

None of us wishes to be at the mercy of the hundred and one acts of our daily life, having to decide, for example, whether we shall get up at this time or that time, or begin work at such a time. We need to make these things a matter of daily routine, so that we regularly and systematically engage in them without thinking, and without decision, thus setting the higher powers of mind free to attend to their particular work.

If we wish to acquire a new habit or abandon an old one, we must take care to start on the new course with as strong and decided a beginning as possible. In order to do this we must summon all the help we can to the desired end; make clear to ourselves the right motives; provide against loopholes for ourselves or others who will drag us back to the old habit, or prevent us from starting the new one, as the case may be; do everything to encourage the new way; make engagements that will prevent us from yielding to the old habit; take public pledges if necessary — reënforce our resolutions with every aid we can, and thus we start on the new course with so many advantages and aids toward making a success of it, and acquire such momentum in the new path that the temptation to yield does not come so soon; and each day that we persist in the new course we get stronger and stronger to withstand the temptation to fall back into the old one again.

Exceptions must not be allowed to occur till the new habit is securely rooted. We cannot, like Rip Van Winkle, say "just this once," and expect to get back easily into the new way. If we drop a ball of yarn, it unwinds, and just to the extent that it does must we wind it up, and so lose the time we would have had to make new windings. Each time we fall back into undesir-



able ways we lose ground, time, and strength, instead of having these to expend upon advancement toward the goal we seek. Each time we resist a habit that we wish to overcome, or strengthen one we wish to acquire, we accumulate help for future success in the desired direction.

Another maxim is to seize the very first possible opportunity *to act* on every resolution you make, and on every emotional prompting you may experience in the new direction. It is putting resolutions *into action* that starts up the new paths in the brain. Prompt and definite action is what makes a life effectual. Dreaming and resolving, floundering about in a sea of sensibility, of emotion, never bringing about concrete deeds — these traits characterize the sentimentalist. There is no objection to the dreaming, provided it be followed up with doing.

One of the most helpful suggestions to this end which Professor James offers is the rule: "Keep the faculty of effort alive in you by a little gratuitous exercise every day"; in other words, by self-denial in some little unnecessary points, merely for the sake of self-discipline. Do something daily just because you would rather *not* do it, and so acquire the habit of conquering your desires in minor matters; thus you will be preparing yourself to stand greater tests when they come to you.

These suggestions are offered here not only as an aid to the nurse in acquiring self-mastery and self-control, but also with the hope that the truths contained in them will aid her in attempts to help her patients to break up old and undesirable habits, and to form new, desirable ones.

## CHAPTER XX

### AIDS TO PSYCHIC TREATMENT

It has been emphasized in preceding chapters that when the physical needs of the patients are all attended to, there yet remain other and higher ones, and that the nurse's work is only half done if these latter needs are ignored.

Each human being is made up of two parts, the physical and the psychic, body and mind. One is as important as the other; they are closely related and interdependent. One cannot be ignored or wrongly treated without the other suffering. One is worthy of as much respect and attention as the other. The good we do in the world is in proportion to the harmonious working together of the physical and the psychic powers with which we are endowed.

Physical disorders need hygienic, medicinal, and palliative remedies; these various means employed are grouped under the one head of *therapeutics*. Psychic disorders require psychic treatment, and means employed to this end constitute *psychotherapy*.

It is mostly for convenience of statement that we speak of bodily and psychic conditions separately; as has been said, in each human being they are so intimately blended that what affects one influences the other; and the most effectual care of our patients will result from keeping in view the curious interrelation between our bodily functions and our immaterial selves.

It has been said that "a normal degree of want of balance gives personality. Its accentuation gives rise to originality and oddness; its exaggeration becomes actual disease." We have to do with an exaggerated want of balance in our patients, but in ourselves and in those with whom we are thrown in daily contact in any walk in life, there are varying degrees of want of balance

in some direction, and it is these varying degrees that give rise to the widely differing personalities that we encounter. True mental equilibrium, then, is very rare. All of us are mentally weak at some point, however intelligent, clever, self-poised, or even brilliant we may be.

Education and the formation of character on a firm basis consist in finding out our weak points and by self-discipline bringing ourselves *to want to do* the things we know we ought to do in order to round out our characters.

The first step in helping a patient, both as nurses and physicians, is to recognize and then admit our kinship to him, in that we, like him, have weaknesses and defects that we need constantly to strive to eradicate. "No teaching," Fénelon says, "is effectual without example; no authority is endurable save in so far as it is softened by example." To put this truth into practice in our daily intercourse with patients places us in the best position really to help them.

Helping the insane is, after all, very simple. It is helping him to help himself. It is not to exact blind obedience from him, but to persuade and influence him so that he will *want to do* the things he ought to do, will want to think the way he should, and will want to feel the way he used to feel. Therein the patient must minister to himself, but we can aid him in self-ministry.

Cures are brought about in various ways. The most enlightened physicians are ready to concede that after the mental invalid has been put in the best possible condition so far as bodily organs and functions are concerned, there is frequently needed an added curative power addressed chiefly to the psychic side. It may be through an emotion, by distraction, or by persuasion — whatever the stimulus used, we often see that these intangible means are helpful in brushing from the consciousness parasitic ideas that have been hindering the patient's cure. Our aim, then, is to help to dislodge injurious thoughts on which the patients focus, by substituting fresh interests to occupy the center of consciousness, so that these will in time crowd the false and morbid ideas to the outer rim, until they finally disappear. A strong aid to this end is to encourage the

patient to help others, his fellow-patients and the nurses. Especially is it good for him to feel that as you are trying to help him, so he can help you. To be interested in something beyond self, that is the secret of happiness. By giving to others we escape from the prison of selfhood; we become emancipated.

"Doctor, I do be thinkin' all the time will I go to heaven when I die; do *you* think that way, Doctor?" This is the daily and hourly burden of one poor sufferer who graphically describes how everything she tries to do from morning till night and far into the night is permeated by this concern for self; it occupies the center of her consciousness; she is forced to lose the whole beautiful world about her in this fruitless query as to whether she will save her own soul; and there is no more miserable being in the institution. Though she were given the freedom of the world, she cannot escape from the prison of Self. This extreme case only differs in degree from other cases of morbid self-feeling in both the sane and the insane.

In your efforts to help a given patient, begin by finding all the encouraging things you can in his make-up. Emphasize these in your own mind and in your intercourse with him; this emphasis encourages optimism, and that is the best attitude toward any reform. Then, to know that he is not alone in his weakness and battling helps wonderfully. Admit your own shortcomings and struggles occasionally to him; take pains to show him some instance wherein he has succeeded when you have failed. As a rule we are too blind to one another's merits, too conscious of their shortcomings; reverse this attitude, and the results will be gratifying to yourself and to those you are striving to help.

We are all going forward, standing still, or going backward. If you will look about you on the wards, you will find that some of your patients are going backward, many are standing still, and a few are going forward. It will enhance your interest in your work if you institute efforts to check the degenerative tendency in the first class, to move the stationary ones into the progressive group, and to aid the ones who are progressing to still more rapid advancement.

We need not be ashamed of physical blemishes; they are often incurable, and are, as a rule, things for which we personally are

not responsible ; but to a great extent we fashion our own mentality, and our mental blemishes are things we should rid ourselves of, both for our own sakes and for those upon whom, by example, we have such an influence, because of daily association with them. Mentality is not a fixed thing, as we learned in the talk on psychology ; it is constantly changing ; we are capable of improvement, of change, of growth, in proportion as we educate our reason and cultivate self-discipline. Our highest duty both to ourselves and to others is to transform undesirable mentality into a desirable acquired character.

We are a bundle of cells, and our lives consist in a combination of reactions ; innumerable ones take place simultaneously, as when we respond to light, noise, odors, heat, cold, voices of friends, ideas that generate in our minds, desires that originate in our physical or mental needs. Forces other than physical that cause us to react are our passions, our religious beliefs, our reason. Right conduct consists in proper reactions to the various stimuli that incite us.

In our bodies, if worn-out particles are not properly removed, the useless products undergo decomposition, crowd and clog and impoverish the tissues, and disturbances and disorders follow. It is the same in the mind. Useless and harmful perceptions which get lodged there, instead of being rejected, accumulate and dominate the consciousness, and interfere with the normal course of thought, feeling, and action.

Conditions of the body give rise to feelings, feelings give rise to expressions. Pessimism, for example, often dependent upon bodily states, shows in the countenance, in the mental attitude to everything, and consequently influences acts. It impairs the will and gives rise to a feeling of insufficiency. It induces the "I can't" that gets in the way of every action ; it causes persons to spend time and energy lamenting the past, so that little force is left to make a more desirable future. It makes one magnify every pain, minimize every pleasure.

The modern conception of *the will* is to the effect that our acts, sane or insane, are largely the consequences of physical conditions, which, if they were more fully understood, would render it possible to foretell the character of the act ; and that the will as a



specific function does not exist. If this be true, it is of supreme importance to keep our physical functions in the best possible working order, since there is no telling when undue fatigue, impoverished lungs and body cells, clogged intestines, or loss of sleep, may influence us in the choice of an act that may alter the whole life. To keep the brain cells nourished, since the cortical cells generate the impulses that govern us, is of the highest importance. The functional capacity of the brain is what really determines the acts of the individual. If there be undue excitation, we see marked pressure of activity, an example of which can be witnessed in any of our manic patients; if the opposite condition obtains, we see the disinclination to thought and action so conspicuous in certain depressed cases.

We can't choose to act one way so long as we *prefer* to act another. Our acts are the outgrowths of our motives every time. Whatever we do is in obedience to some sentiment or idea, unless it be an instinctive act. Heredity and education strengthen our motives one way or the other. We can be slaves to good or to bad impulses.

Throw around a person the right conditions, fortify him by desire to choose the right, strengthen him at weak points, modify conditions that make the strain too great, keep his bodily health and strength up to par by food, exercise, and sleep, and then know that his actual choice depends upon which is stronger, the cumulative power of these right conditions, or the temptation; and upon which *is* stronger depends his success or failure in coping with the situation. It is all very well to tell a person to use his will, but do all you can to bolster up his will, and don't put it to too strong a test. The old story of Ulysses and the sirens shows the wisdom of fortifying one's self in advance so that success, even against odds, is attained.

*People are what they are because at the time they must be.* Absorb this truth; it will make you wisely indulgent. Then set about to make them different by helping them *to want to be different*. All weakness, all meanness, all error and sin will thus elicit only tolerance and sympathy, and a desire to help to better things. But let us remember that because any given

act is the result of foregoing motives, it does not follow that other acts must be identical or similar. We are at liberty to change our motives, to create a new way of looking at things, to cultivate other ideals and hold to them.

We need now to consider briefly the vexed question of responsibility for acts. It is a mistake to suppose that because a patient deliberates and finally chooses a wrong course of action he is "responsible." The very fact that he deliberates and chooses wrongly shows that there is a disturbance in the functioning of the higher centers, so that he cannot inhibit wrong thoughts and later, wrong acts.

In judging of the responsibility of a person with reference to a given act, many factors have to be taken into consideration — the hereditary influence, his environment, his personal characteristics and predilections, his condition at the time of the act, and the immediate agents which provoked it.

Our attitude toward the misdeeds of patients will distinctly change as we get more enlightened views concerning them. These being obtained, we will never resort to the absurd "law of retaliation." Our business is to prevent the recurrence of misdeeds by studying into the conditions and influences that lead up to them. We must then seek to change unfavorable circumstances, that can be changed, and to bring about the right mental attitude toward those that must be endured. Brutal repression and injudicious indulgence are alike harmful in dealing with patients. First understand the causes of their many acts, then you can forgive. But do not stop with merely forgiving — that would be weak. Set about to help the delinquent to acquire a *desire to do better*, then the need to forgive will not again arise, or at least not so frequently. We must not expect miracles. All these steps must be evolutionary.

Modern psychologists believe, not that thought, feelings, and volition exist as separate entities, and that disorders in the one field are entirely distinct from disorders in the other, but that the cerebral functions are composite, that they work together, and that disturbances in one function must of necessity create greater or less disturbances in others.

As we said before, acts are regarded as the result of functional

activity of the nervous system. "Men's characters are determined," it has been said, "by their visceral structure." This conception of ourselves ought to tend to do away with the old notion of regarding the body and its functions in a degrading light, and as part of our baser natures; it ought rather to make one feel that each "part and tag of me is a miracle," and that body helps soul on its way no less than soul helps body.

To regard conscience as that still small voice within that tells us what is the wrong course and what is right, is now considered antiquated in the light of modern research. Our so-called consciences are constantly changing and are affected by our bodily states to a surprising degree, and are at the mercy of them to a degree that forces upon us the conviction that it behooves us to dignify and safeguard and keep in the best of conditions the life of the body, if we wish to further the best interests of all that we include when we speak of the life of the soul.

## CHAPTER XXI

### APPLIED PSYCHOLOGY

Who is there who has not at least one besetting sin? It may be lack of punctuality, it may be sharpness of speech, it may be garrulity, or a prying curiosity into the concerns of others, it may be slackness about dress or person or belongings, or forgetfulness — whatever it is, it makes us less efficient than we would be if we were to overcome it. To set to work to overcome the besetting sin which probably each of us knows better than any one can tell us, is a duty of to-day. In the matter of lack of punctuality — just a few minutes late in getting the wards in order, in pinning on apron straps or putting on caps — these are trifles, yet physicians come to associate with certain ones the condition of being almost but never quite on time.

It is worse than useless merely to talk about it or about any shortcoming. It does no good whatever to harp on besetting sins and deplore them over and over. We have enough instances on the wards of patients who go about from morning till night lamenting because they have not done differently, and never getting beyond that. Stop talking about your feelings. After once acknowledging to yourself that you have a particular fault to correct, cease to dwell upon it, or even to regret it. If you find yourself behind time, waste no time nor words in saying you are sorry, or even thinking it (unless it is your duty to apologize to some one for it), but make a vivid picture in your mind of being on time, and keep this picture before you. In other words, refuse longer to imagine it possible for you to be anything but early. In doing this you lessen the old brain impression of being late and strengthen a new one of being early, and so a real reform is started.

This same rule applies in dealing with the faults and failings

of others — with the patients. To hold up to them their faults repeatedly is worse than useless, for in so doing we strengthen their impression of these very faults. Encourage, stimulate, overlook, but be careful how you constantly emphasize shortcomings. That is the wrong pattern; put a newer and better one before their eyes. Everything that you can do to make them lose sight of their faults will help them to lose the faults themselves.

If we would let all the annoyances of life slide off without leaving their imprint, it would be far better for us. Instead of that, we are too apt to let them grate and grind, like sand in the wheels of a machine, and the friction produced causes wrinkles in our faces and wrinkles in our souls.

It may be you are given to moods. What if you are? It is idle to bewail the fact. Persons who are way down are just as often way up. This kind of a see-saw of happiness and unhappiness is experienced by those whose capacity for getting the most out of life is the keenest. This is not saying that we are to encourage our moods, but that we are not to resist them. A very helpful writer on this subject, Annie Payson Call, whose books are so helpful in aiding one to adjust himself to the varied relations of life, says one's attitude toward a mood should be this: recognize it *as* a mood and say to it: "Come on. Do your worst. I can stand it as long as you can." This is the quickest way to make it wear itself out. In other words, treat it as you do one who tries to tease you — refuse to be teased, and you take the wind out of his sails, as Miss Call says.

This writer gives some sensible advice in regard to the various sources of irritation we encounter in daily life.

Suppose some one has a disagreeable habit; you are annoyed by it. The annoyance grows on you till this one habit perhaps crowds out of your sight every virtue of the individual, and you find yourself thinking of him only in relation to this annoyance to you. Does your irritation prevent him from pursuing the habit? No. Does it do any good to you? It only increases your discomfort and prevents you from seeing him except in a distorted light.

The whole complexion of things would be changed for us if



we would cultivate more tolerance for the frailties of others; as we become more tolerant, we get clearer views of excellences, and failings drop out of sight. The writer just quoted shows how this result may be brought about, by being quite willing that persons should persist in annoying habits. For example, say to yourself, "I am quite willing — — shall make that disagreeable noise with her mouth," and, as you hear it, say to yourself, "Yes, I am quite willing; do it again, please." Persist in this, and it will in time induce a spirit of tolerance that will allow you to let the habit pass unnoticed, so far as *you* are concerned. Think what a relief to the nervous system to have this source of irritation removed! We cannot reform the world, we would have no time for anything else if we set ourselves the task of correcting all the ill-bred habits of persons with whom we touch elbows every day. Each individual has to live his own life in his own way; if the world is out of joint, we need to remember that it is only overwrought persons who feel that they are born to set it right. Criticism and preaching do but little good; suggestion and kindly persuasion may help, but example will do more than anything else to make people over into what they ought to be. The sooner we learn this lesson, the sooner will a weight be lifted from our own shoulders; the sooner we can bring ourselves to take and keep this tolerant attitude toward the failings of others, the freer shall we be from the annoyances that their failings induce.

In the matter of abusive patients — we all know how there are certain ones who take a malicious delight in using the most vile and untruthful language concerning one. They fasten upon your peculiarities and exaggerate or willfully misrepresent them; make accusations wholly without foundation, and yet, so ingenious are they that they manage to make them in a plausible way, with a show of truth, and you find yourself chagrined, often humiliated before the physicians, by these unjust and untruthful accusations. You see the patient capable of using reasoning power sufficiently to make her accusations telling ones, and this makes you think her capable also of refraining from such things, so you find welling up in your breast a resentment for her that nothing will overcome. You show this resentment in looks and

tone, even if you do not mean to do it, and this very resentment increases the patient's desire to annoy you still further.

What you need is sympathy. You need to see things from her point of view; to reflect that she is insane; that her judgment is warped, her ideas distorted, her moral sense blunted; and that because for the time she believes you to be all these things she says you are, she is to be pitied and excused. Take it on a broader than the purely personal plane; reflect how it would be if you really were the person she says you are. Would you blame her then for saying these things about you? Yet that is what you are doing, for she thinks you are what she says you are, so, from her point of view, form your judgment of her conduct, and you will find yourself losing all resentment toward her. One of our best-loved nature writers gives us a hint as to how to act toward persons who are trying to annoy us, when he speaks of the calmness and dignity of the hen hawk when pursued and worried by king birds or crows: "He seldom deigns to notice his noisy and furious antagonists, but deliberately wheels about in that aërial spiral, and mounts and mounts till his pursuers grow dizzy and return to earth again. It is quite original, this mode of getting rid of an unworthy opponent, rising to heights where the braggart is dazed and bewildered and loses his reckoning! I am not sure but it is worthy of imitation."

Instead of taking this lofty view of the situation, one is more inclined to think, "She knows better; she has no right to talk that way." So you harden your heart against a person who is deprived of her reason and her self-control. Try pitying and forgiving her on the ground that she is not responsible, and see how differently you will feel toward her. She can't see things as they are, but should you show resentment to a blind woman? Because she strikes you, are you to hit back? And hit a sick woman? Yet this is just what you are doing when you show animosity in look or tone; your nervous system is hitting back her nervous system, whereas it is your duty to soothe and help to restore her tired nerves, thus aiding her to regain a normal way of looking at things.

Savages slay people with whom they differ. We don't do this

nowadays. Are we always careful, though, not to harbor hatred and revenge in our hearts? Let us guard against showing resentment in tone or glance, or in using "discipline" toward the unruly patient who has offended, or spoken ill of, or ridiculed us. If we do these things, we are killing by inches our own tolerance and love for a fellow-being, warping our own nature, and drying up the milk of human kindness; and the effect is not alone upon the patient, who sees that we are failing in a spirit of forbearance and forgiveness, but its effect upon our own nervous systems is corroding. One's peace of mind and serenity of soul are lessened every time one gives way to such a weakness. Resentment, ridicule, and sarcasm are all corroding influences. And has it ever occurred to you how cowardly it is to employ these weapons against a defenseless, brain-sick patient?

"But," you say, "they are not all defenseless; they show a surprising shrewdness and malice in their attacks upon us; they take it for granted that, as insane patients, they have the liberty to pounce upon our weaknesses and infirmities and hold them up to ridicule, and they don't even stop at the truth, but invent untruths about us that we cannot endure to hear repeated, knowing that the doctors may be influenced by them." The truth of these statements cannot be denied. This is one of the hardest things you have to bear. The physicians are not insensible to the trials of your position, and you must not think that because they investigate complaints made by malicious patients they distrust you. They are only seeking for the truth, and the way to get at the truth is to investigate impartially. If you are innocent, you should court investigation instead of resenting it. It is only just to both you and the patient that investigations are made. But how many times is a different view of the case taken, a hypersensitive, innocent nurse thinking that the physicians distrust her because of necessary investigations. Some of you, I am glad to say, are able to look at the matter less sensitively. Beware, however, that you do not go to the opposite extreme, and take it for granted that the physician is always ready to believe the nurse; above all, never allow yourselves to express or to intimate to a patient that because she is insane

the doctors will not credit her statements. Such a thought lodged in a patient's mind by an unscrupulous or a thoughtless nurse would make a patient distrustful of the entire institution, and desperate in her feeling of helplessness, believing herself unable to get an unprejudiced hearing.

Be deliberately kind to the person toward whom you feel unfriendly, and you will be surprised how soon you will actually begin to feel kindly toward him; laugh with him if possible; there is nothing that so quickly establishes a friendly footing between persons as being able to have a hearty laugh together.

If love, hope, joy, trust, self-control, peace, generosity are lacking in a nature, and we wish to do good to the one so impoverished, the most effectual way to arouse these qualities is *to be* the embodiment of these ourselves; let them shine out of our lives as a radiance, and they cannot help in time having the effect of waking these sleeping qualities in others and so of counteracting unworthy emotions that have dominion over them.

If we entertain thoughts of love, of harmony, of good will toward an antagonistic patient or an associate, harboring of these feelings must in some measure, often more than we dream, arouse the better possibilities within him.

I have dwelt on these things, many of which are as trite as truth itself, not only because they are aids to self-help, but also because they contain the same principles of mental hygiene that you need to apply in the daily intercourse with your patients if you are to nurse their sick minds as well as their sick bodies. The old advice to the physician, "heal thyself," is applicable to the nurse as well, for the faults and vagaries of the insane are only the exaggerated reactions of similar ones that we see about us in sane persons, and that, if honest, we must admit we often encounter in ourselves.

You know that there are certain instinctive tendencies in us as human beings that bear a large part in our lives, even though they are often overlaid and overruled by the higher brain processes — they are the *native instincts* or *impulses*, and they give rise to certain reactions. In our patients the higher brain functions are more or less impaired, so that we have these native impulses in the ascendancy; these show our kinship with the

lower animals; while the higher brain processes show wherein we surpass the brute creation.

What are these native instincts that are more or less overlaid and controlled by the higher functions, but that become so prominent in our patients because of their alienation from the normal? *Self-preservation* and *reproduction* are the principal ones, and out of these grow most of what we call the *native reactions* — fear, love, curiosity, imitation, emulation, ambition, pugnacity, pride, ownership, destructiveness, and constructiveness. Perhaps if we realize what these reactions are and recognize how innate they are in the lives of all of us, we shall be better able to understand some of the manifestations of our patients, and, knowing their deep-rootedness, shall perhaps grow more charitable when the reactions crop out in exaggerated and uncontrolled and perverted ways; not only that, we shall also learn how to turn these very instinctive tendencies to good results.

Since in our patients the reason is in part disturbed, it is easily seen that the native impulses are the materials with which we have most largely to deal. These native impulses, tendencies, instincts, are perhaps the ones you will need most to reckon with, especially with a certain class of patients.

You will see many patients in whom the *instinct of fear* has assumed a position of tremendous prominence, crowding aside all judgment, coloring all experiences. To allay fears, not by argument, but by undeviating kindness, by furnishing things to bring out other emotions and so crowd out painful ones, is a part of the nurse's duty to such patients. The instinct of fear should never be used as a means of discipline or of reformation. Only an unscrupulous person will try to control patients by appealing to their fear of punishment. On the other hand, the *instinct of love* can be utilized at every turn to lead the patient into right ways of thinking and acting. Make your patients love you by being what you wish to seem to them — real helpers and friends. Goodness is more contagious than we are wont to realize.

*Curiosity* we often see in an exaggerated form in certain excited cases, and in some deteriorated ones — the alert curi-



osity of the hypomaniacal patient, the peering, open-mouthed curiosity of many cases of dementia præcox, and the restless, aimless curiosity of senile patients. Sometimes by catering to this instinct the attention can be gained and led to something more and more helpful, and better behavior can thus often be instituted, even though there be little or no hope of improving the mentality as a whole. Many depressed patients can be roused in this way, after a certain time, and so drawn away from their introspection. Find what are the natural interests of your patients, and engage their activities in this line; then lead up to better and better things by association and by connecting each interest with the one that went before.

*Imitation* is an instinct we can enlist at every turn; of this we have spoken elsewhere in emphasizing the value of example over precept in dealing with the insane. We see its power in the influence of patients on one another, we see its far-reaching power in the effect of home life and surroundings and inherited instincts in the young everywhere, and the same rules that should govern parents and teachers should prevail with us: set a good copy, be careful that the pattern is right; for imitation is one of our strongest native reactions. In this connection we have *emulation*, which is so closely allied to it and which is responsible for so much of the advancement made by individuals and races, each wanting to do as well as the other and then a little better, and so we come to *ambition* — all three instincts capable of much good if controlled by the higher faculties, but all liable to assume undue proportions in a poorly regulated life; yet the very traits that have proved the patient's undoing may in many cases be appealed to in order to bring about his restoration to mental health.

*Pugnacity* is one of the instincts we will find overdeveloped in many persons, both sane and insane. It is one of the few that we should seldom appeal to, but seek rather to stifle by appealing to love instead. We can, however, sometimes enlist the patient's pugnacity against some of his own downward tendencies, so that this, together with his pride, will help him to conquer them. This is legitimate, but try not to call out this quality except in such a direction.

*Pride* is another instinct that is offensively present in many of our patients, but is a trait that we can often enlist in the regenerating processes we are trying to bring about.

Cultivate the *instinct of ownership* instead of discouraging it. This feeling, so ingrained in human nature, leads to order, neatness, and method. The collecting impulse in the insane is the perversion of this instinct, but the efforts of patients at keeping together their belongings is the natural expression of this instinct, and should be fostered and almost never discouraged.

*Construction* and *destruction* are closely allied. A child will tear things to pieces, but if you give him some blocks with which to build, the same activity that went to destructiveness will be directed to constructiveness, and what is true of children in this respect is true to a great extent of many of our patients. If you find a patient purloining the towels and bureau covers and fashioning various things out of them, do not chide her for it; be glad that she has the desire to do things; encourage it by providing material with which to work. One of the first encouraging signs in many patients is this seizing upon the most unpromising materials and making them answer the purpose of ministering to the constructive instinct. Even greatly deteriorated patients would better be employed playing with blocks, as children do, or putting puzzle maps together, than in tearing things to pieces and giving way to destructive tendencies generally, as they will be likely to do if constructive ones are not catered to when the time is ripe for it.

Everything that can increase our knowledge of the patients aids us the better to help them. If we see why a thing is so, it tends to make it easier for us that it *is* so, even if the condition is a trying one. The deplorable manifestations of many of these patients can be good-naturedly endured if they can't be cured, but they can often actually be used as stepping-stones to betterment.

The nurse of the insane learns many things about the past lives of her patients that should be guarded as sacredly and interpreted as charitably as befits one trusted with the care of this most unfortunate class of humanity. Patients whose lives have been sinful should receive compassion always, never

scorn. It is not for us to judge, but to try to understand, and pity and restore. All life is a struggle. The history of every soul is one of struggling, suffering, sinning, resisting; and, in the long run, achieving redemption, or meeting defeat. Our own battles, our hard-won successes, our many failures, about which none know as we know ourselves, should keep us mindful of the battles of those around us; and pity for those who fail, where perhaps we have conquered, should be given unstintedly.

As nurses and physicians we come close to the souls of our patients; we see deep into what has been felt and endured; we see how events and conditions have seemed to conspire to make defeat inevitable; the deeper our insight, the wider should grow our tolerance, the fuller our sympathy, the more generous our help. It is literally true that to know all is to forgive all.

## CHAPTER XXII

### MENTAL HYGIENE

*Mental hygiene* is the prevention of mental disease and the maintaining of mental health. It must consist of an education which takes into consideration, in a given case, peculiarities of constitution and temperament, the choice of appropriate occupation and pursuits, the avoidance of errors in religious teachings, the right attitude toward and the regulation of the sexual life, training in right thinking, and encouragement to right responses when the various influences call for action.

It is as important that the nurse of nervous and mental invalids learn the principles of mental hygiene as that she understand those of physical hygiene. Dr. Adolf Meyer, who, as Director of the Pathological Institute of New York State, has done and is doing so much to improve the medical work in the State hospitals, in one of his lectures to assistant physicians in State hospitals, emphasized the fact that "hygiene of the mental faculties is as necessary as hygiene of the bowels"; he said that we give the truest help to our patients when we aid them to get their mental activities adjusted on normal lines; he holds that in order to do this we must appreciate the undercurrents in their lives, provide proper food for their normal instincts, and so guard against perversions; relieve tension and anxiety; soothe excitement; allay fears; and train to good and useful habits.

Mental hygiene, of course, presupposes hygienic bodily conditions — a sound mind in a sound body. The preliminary step, then, in mental hygiene is to secure, later to maintain, physical health.

Good spirits are more dependent upon a body that is working in harmony than we are inclined to believe. The contrasting states of mind, optimism and pessimism, are largely the result

of bodily conditions. Fatigue can cause sadness, ideas of negation, and of persecution. It can lead its victim to disparage everything around him, and can plunge him into the slough of pessimism. Even the true lover of his kind, the altruist, whose life is spent in beneficent acts, may, under the benumbing influence of fatigue, become selfish, and under continuous fatigue, prove incapable of reacting against obsessions and impulses grown irresistible. Mental states, in their turn, act upon the organs and functions of the body. Worry is a most potent factor in the causation of many physical disorders; chronic diseases are especially aggravated by this destructive process. It has long been established as a fact that certain powerful emotions, such as fear, or anger, may affect a woman's milk so that her child, if nursed soon after, will have convulsions. We have in this fact an illustration of the influence of the emotions upon the secretions of the body, and consequently upon the welfare of the body. We have other familiar illustrations of the influence of mental action upon the secretions: sadness acts upon the lachrymal glands causing tears; thought of savory food produces a flow of saliva, and so on. In these facts we get a hint as to the hygiene of our thought life — that since thought and emotion really influence the secreting cells of the glands, when the result of thought and emotion proves undesirable and harmful, we should change our thoughts and feelings by getting up new interests, thus by substitution dispelling injurious ones.

We have already learned that certain changes take place in our brain cells during thinking. Thought is the product of brain activity. When thought becomes disturbed, when the emotions become hypersensitive, some change takes place in the nerve cells and their communicating fibers; upon the condition and activity of these nerve cells our activity and consequently our lives depend. To think aright is mental health. Ideas are the levers that move to action. So long as the thought is right, it must follow that successive steps will be right also.

In acquiring mental discipline and poise, as I have said, the avoidance of worry and the cultivation of a hopeful spirit are of special importance. Then we must let go of overweening



ambition; conserve the energy so that all efforts count; stop unavailing regrets; cease to dwell upon our own mistakes — to cry over spilt milk; and cease to harp on the mistakes of others. We must refuse to cross bridges till we come to them; try to get a clear view of every situation we are called to meet; learn to recognize essentials, to ignore non-essentials; to overcome our own selfishness and obstinacy at every turn; finally, we must school ourselves to control the emotions and passions instead of letting them control us.

Environment has more to do with one's well-being than we are wont to realize. There is a marked difference in persons in this respect, but all of us are influenced by the rooms in which we live — their heterogeneous arrangement, the colors that predominate, that harmonize or quarrel with one another, the noise or quiet that prevail, the purity or impurity of the air, and the sympathy or antagonism of the mental atmosphere. We all act and react upon one another, and it is true of every one, even of the most self-contained, or of the most callous, that we do our best work in what we feel to be a sympathetic environment. Persons with an exaggerated sensibility are of course much more readily affected by their surroundings than are others, and all nervous and mental invalids come under this head. Nurses and patients react upon one another to a surprising degree, and in numberless ways. What you are is of the utmost importance to those around you as well as to yourself: quiet, calmness, systematic and well-controlled conduct on your part, are conducive to the same traits in your patients. A nurse with self-control and poise can go into a disturbed ward where everything is at sixes and sevens, and succeed in a short time in bringing order and quiet out of chaos; while one who is easily flustered, is made more so by such a situation, and her well-meant efforts only serve to increase the confusion she encounters. The one has acquired a self-mastery that the other will need to attain before she can hope to have a beneficial effect upon her patients. This self-mastery is, as I have stated, primarily dependent upon the physical condition; and to keep the body up to its best, attention to diet, fresh air, cleanliness, sleep, are of prime importance; the avoidance of stimulants, the adherence

to good habits, and a clear conscience, are likewise important; and a mental activity that makes one alive to everything about him, thereby increasing his knowledge and power of applying it, goes far toward completing this desirable equipment.

Let us further consider the emotions, since they are so potent in governing our lives. We have already learned that every stimulus sets up some kind of a reaction; that every sensation causes some sort of motion in the body (not necessarily appreciable to us; it may be motion in the cells that make up the various organs); and that every feeling produces a movement. Some psychologists, however, say that this is putting the cart before the horse, and that emotion follows upon the bodily expression of it, at least in the coarser emotions. Professor James teaches that we first perceive an exciting fact and that our feeling of the bodily changes, resulting from the perception, constitutes the emotion. For example, some one strikes me, I strike back, and then get angry because I strike; or I see something that makes me tremble, and because I tremble, I experience fear.

Whether we regard emotions as causes of the bodily expressions of them, or the bodily expressions of them as the cause of the various feelings, certain it is that they are closely related, and are of tremendous importance in our lives. For our purpose it is more profitable to study what bodily expressions accompany certain emotional states than to inquire further into which is the cause and which the effect. So we will cling to the customary way of speaking of them and say, joy expands, grief contracts, instead of saying that we expand our muscles and so feel joy; contract them, and so experience grief.

The depressed person sits wrapped round and round in self; a barrier seems to shut him off from his fellows. Depressing emotions alienate us so that those we love, and the things we were once interested in, seem foreign; at first they fail to arouse the accustomed interest; later, they seem to belong to us no more; from being in the beginning cold and *blasé*, we come to feel a growing sense of inward loneliness and isolation from everything.

On the other hand, the tendency of elation is to make one interested in others. There seems to be an affinity between

joy and tenderness, and it is a natural step from being happy ourselves to trying to make others happy. The joyous emotions bring us near to the sensible material world, and we joy in it and in our fellow-creatures, and feel at one with so many things that, like Stevenson, we come near to being as happy as kings. Other things being equal, the more points of contact we have with things, the broader the interests, the happier we are, and the happier we make others. Sympathy is an evolution of the feeling of selfishness, although the two seem so widely separated. It is a transfer of our own selfish feelings to another personality, so that we feel with that other.

Degeneration of brain cell is believed to result from overstrain of many kinds, from worry, long-continued excitement (even of a pleasurable kind), from artificial stimuli, from overstudy, and from insomnia. All these tend to act unfavorably upon the brain cells of healthy, normal persons, and of course their effect is even more deleterious upon those who have inherited unstable organizations, and upon others whose arterial tissues are inclined to weakness. Youths who break down early from the strain of a course of study which has no such effect upon their fellow-students, show either hereditary or constitutional weakness of their nervous systems; precocious children who early show such startling promise of mental acuteness, but later dwindle into commonplace or even subnormal intellects (thus showing their lack of staying power), young persons who under a little extra stress and strain succumb to unfavorable conditions, and perhaps show early dementia — all belong to this unfortunate class. It should be the aim of parents and teachers to safeguard such unstable individuals at every turn; to seek in childhood to round out their development by making healthy little animals of them; to be slow about pushing their education; and to be chary of furnishing stimuli to their emotional natures — such stimuli as they would get in musical training, novel reading, and in much of what goes under the name of religious teaching and influence. The crucial times in the lives of these neurotic persons should be provided for in advance by so controlling their work and environment that these hard places may be passed in safety — the period of puberty, the child-bearing periods, the climacteric period.

In order to lead our patients into self-controlled conduct we must furnish them the help that right example gives ; aid them in enlarging their interests by good reading, by attention to wholesome natural things, and to the right way of looking at the daily tasks we and they are called upon to do ; teach them to understand the necessary and really ennobling part these play in the whole of life, if we but learn to see them as related to the whole of life, and not merely as separate items of drudgery.

It is all very well to have beautiful dreams, high ideals, and lofty conceptions, but these alone are of small value. They are in mental hygiene of as little value as unused gymnastic apparatus is in physical hygiene. The apparatus looks well, and impresses the casual visitor, but it is decidedly pernicious to the one needing exercise of the muscles, if the mere having procured it satisfies him and lets him forget that he puts it to no use. We must put our thoughts and feelings into acts, if our mental faculties are to get their needed exercise. We must bring our dreams of doing good to the test of actuality. We must make religion a religion of deed, not of feeling alone ; must see that pity blossoms into kindly acts ; that charity overlooks unkindness ; that our vaunted love of beauty and of harmony is so much a part of our daily lives that every one with whom we come in contact feels the effects in added beauty and harmony in their own lives ; in a word, we must transform emotions into actions by relating all our fine ideals to matters of everyday living.

Mental hygiene demands that each one of us, you in your work, and I in mine, faces each situation as it presents itself, and acts up to our best light as to how to cope with it. It is of small profit to think concerning this or that future situation that may confront us, "I must do thus and so, because to do otherwise would be wrong"; that would be going out in imagination to meet a situation which does not exist ; and although we meet it and conquer it thus, in the imagination, it does not really strengthen us. It is like fighting toy soldiers. What will strengthen us, though, is to train ourselves so that we habitually ask of each question as it confronts us and calls for action, "Is it right ? wise ? best ? Is it fair to another ? Just to myself to do this, and this ?" And having asked and answered,



act according to what really seems right, wise, best, fair, just, regardless whether it is easy or difficult of accomplishment. As Professor Thorndike says: "Men become efficient and decent only by behaving efficiently and decently. To work is the only cure for laziness; to give is the only cure for stinginess; to tell the truth is the only cure for lying."

In order to control our acts, a foreground of preparation is necessary, which consists in controlling the mental states which lead up to them. And in order to control the mental states leading up to them, we need to arouse the feelings that will lead up to the right mental states, and to repress those that would lead to undesirable ones. To this end we must put ourselves in favorable situations; we must learn what are the useful instincts, and give them a chance to be exercised in legitimate ways, so that they will become habits; we must learn to inhibit responses to unworthy instincts; acquaint ourselves with our own weaknesses; and learn to present clearly to ourselves the satisfaction and enduring good that follow worthy acts, however (though not necessarily) difficult, and the discomfort and far-reaching harm of unworthy ones, however alluring they prove.

One of the most effectual ways to arouse right feelings that shall move to right actions is to fasten attention upon something of absorbing interest, so that we come to lose sight of the thing we know we ought to refrain from doing. It is really very simple, after all; it amounts to substituting one absorbing interest for another, until the one comes in time to crowd out the other.

We may have to help ourselves by avoiding things which tempt us too strongly, until we acquire sufficient self-mastery to cope with the situation face to face. This may seem cowardly in a way, but it is often the safer, if not, indeed, the only way. "The better part of valor is discretion."

Another way to strengthen ourselves in right conduct is to face squarely the uncomfortable results that follow yielding to wrong acts, and also to look what appears so alluring full in the face, and, in sober moments, ask ourselves if a given course is really so much to be desired as we have fancied it. By bringing the temptation near in thought and under the cold light of reason,



at times when we are not blinded by passion, we will often find that it was merely distance that lent enchantment, and that, as Professor King suggests, the siren has a painted face; her smile is a leer; her song coarser than we thought. Thus we shall see her as she is, and when we so see her she will lose all power to charm. Yet, so potent is the force of habit, it will be well to keep busy at some absorbing task if circumstances decree that we must sail near the siren's rock, lest we forget her leer, forget her painted face, and her cruel purpose, when her singing is wafted to our ears.

Mental hygiene demands that we avoid unprofitable looking within. If I look myself squarely in the face, see myself as no one else can see me — because no one else can know the strange mixture of good and bad — what shall it profit me? Nothing, if I let regret and remorse be the final result. They have their place as a means to an end, but in themselves are relaxing, enervating. After this scrutiny of ourselves, we need to right about face and march away, not only from wrongdoing, but also from the thoughts of wrongdoing; we literally need to put the thoughts of our sins from us as far as the East is from the West. Further than that, we need to set about the doing of some concrete good. In certain natures the tendency to self-accusation and self-depreciation is so great that examination of self is exceedingly harmful; it paralyzes, produces inaction, obtuseness, and wasting of all the powers. Such persons need to remember to be merciful to themselves, though sinners; to give themselves credit for their good deeds as well as for their bad; they need to recall where they have lent a hand here, offered a cup of cold water there; stood up for principle when it would have been far easier to have kept silent; been merciful when others, in efforts to be just, have been harsh and unforgiving; and, in this distinct effort at seeing the good in themselves, they will come to lose sight of the evil, and so be better fitted to overcome evil with good.

We need, then, to be introspective enough to face ourselves unflinchingly, face every situation squarely, and determine whether we are meeting it honestly; ask ourselves if we are being our best selves, giving our best to others; and, after making

sure of these things, we need to forget ourselves in action — in doing well the very nearest thing that lies at hand to do.

It has become a truism that we Americans are too strenuous. We keep ourselves busy and excited all the time ; there is undue tension in our muscles and in our habits of mind ; we forget to relax, to take advantage of the power that comes through repose ; we need to remember to stop and breathe deeply oftener ; we need to apply the principle of relaxation to our daily lives, instead of merely reading the numerous books that have been written on the subject. We need to stay our haste, to make delays ; need to reflect that too much eagerness, breathlessness, and anxiety are signs of weakness, not of strength ; that they betoken a lack of inner harmony and ease, and beget feelings of unrestfulness in others.

## CHAPTER XXIII

### NORMAL AND ABNORMAL MENTALITY

BEFORE studying the manifestations of insanity we need to take some preliminary steps — to see first how the normal mind works, then the abnormal. In *psychology* we study normal functions; in *psychiatry*, deviations of mental functions from normal standards.

In considering any organ of the body we are interested chiefly in its function; in other words, in what it does, in what part it plays in the working of the body; for example, the function of the heart is to pump blood through the body. In studying the processes of intellectual life, we study *psychic functions*. We know these must have some organ. That organ is the brain, or to be more specific, the cortical cells in the forebrain or cerebrum. It is in these cortical cells that perceptions occur, and here that the impulses to voluntary movements originate, and also here that memory pictures of other sensations, perceptions, and motions are stowed away.

*Sensations* are the first steps in brain activity. They arise from stimuli coming to us either from external objects, or from our own organs, and give rise to *perceptions*. These perceptions take place by means of attention to stimuli, and by means of thought, and of memory of previous stimuli. Perceptions are accompanied by pleasurable or painful feelings which we call *emotions*. These constitute our mental or psychic activities. They are intimately blended, and it is only for convenience of study that we speak of them as separate processes.

It is believed that the higher the race or the individual stands mentally, the larger and heavier the forebrain is in proportion to its mass; and the higher a creature is in the animal kingdom, the deeper and more complex are the furrows or convolutions on

the surface of its brain. In a rat or a bat the only furrow is around the Sylvian fissure, but as one goes on up the scale, more and more convolutions appear. Foxes, dogs, and wolves have more than rats and bats, and of course are more intelligent; apes have more than foxes and dogs, and men have more than apes. Children's brains have a scarcity and shallowness of convolutions, but as intellectual life deepens, the convolutions deepen also. Consequently, idiots' brains show a poverty of convolutions, while the brains of persons noted for mental vigor present great variety and depth of these furrows.

The brain cortex is made up of millions on millions of cells embedded in connective tissue rich in blood, and probably all communicating with one another by minute fibers.

By means of the nervous system we are brought into relation with the outside world; the brain being the center and the spinal cord and nerves working together, we are enabled to receive impressions from without, register them, appreciate them, store them up for future comparison, respond to them, either voluntarily or involuntarily, and form ideas and opinions, which ideas and opinions control our acts, and in time make up our characters.

Our interest here is chiefly in the workings of the *brain* as the *seat of intelligence*. What is it to be intelligent? It is to see and to know what we see; to feel and to know what we feel; to hear and to know what we hear; to smell and to know what we smell; to taste and to know what we taste. In other words, it is to be able to receive impressions through our senses, compare them with former similar impressions, remember what we learned of these former impressions, and in the comparison to form correct judgments as to each experience that comes to us. Sense impressions vary in kind and intensity; they are dependent upon the state of excitability of the organs of sense as well as of the centers in the brain, and upon the force of the particular stimulus, and also upon the influence of other outside stimuli affecting us at the same time.

We do not get separate single sensations as such. At every moment of our lives numerous sensations are coming to us through our eyes, and ears, and all the other senses, and these

many sensations coming to us at the same time become mingled, and form what are called *sensory concepts*; these unite and become *general concepts*, and so we have what we call *ideas of things*, and from them we form *judgments* or come to conclusions.

In morbid conditions, instead of sense impressions coming to one correctly, certain *sense deceptions* take place, giving rise in turn to false ideas. These sense deceptions are called hallucinations and illusions; the false ideas, when they become beliefs, are called *delusions*. In *hallucinations*, due to some abnormal stimulation of the brain cells or sense organs, the patient thinks he perceives something which really has no existence; he hears a voice when there is no voice; he sees a person when perhaps he is the only one in the room, and in like manner he tastes and smells things which have no objective reality, or perhaps he experiences a feeling of weight upon his muscles, or some sensation in his skin which is not caused by anything in contact with those parts. In the case of *illusions*, false impressions result from misinterpreting real objects. The patient hears threats and curses and agonizing screams in the ordinary sounds about him, sees ghosts in the clouds, animals in small, inanimate objects, and so on.

Our *ideas* are accompanied by certain feelings, or *emotions*, which are pleasurable or otherwise. All the emotions we feel at a given time combine to form our *mood*. Every idea gives color to our feelings of one kind or another. If we think of early spring, it depends upon what our associations have been with it what our feelings shall be. The thought may be associated with feelings of hope and promise, of irises and doves and loves, of bluebirds and hepaticas, of trout brooks, of planting a garden, of colds in the head, or house cleaning, and so on. And according to the idea do we experience comfort or discomfort, pleasure or pain. So we see that an idea which calls up a pleasurable emotion in one person may call up just the opposite in another, depending upon what his past experiences and associations have been with that particular idea.

We differ widely in health in regard to our emotional life, and when insanity develops, the emotional manifestations are cor-



respondingly varied. Some cases present dulled, others exaggerated, emotions. Some experience emotions that are incongruous; that is, that are at variance with the sense impressions they are receiving at the time, showing that they have called up ideas from their inner consciousness and are feeling in accordance with them instead of with what is really happening to them from without. In other cases, although the emotions are in accordance with the patient's actual sensory impressions, great instability is seen, and the person shifts from one emotion to another according as the various ideas rapidly present themselves to him.

Our emotions are also influenced by the slowness or the rapidity with which ideas come to us, and the rate at which they come is dependent upon a number of conditions. The shortest time in which one idea follows another has been estimated to be one eighth of a second. Our attention and our wills can to a certain extent only control the procession of ideas through our minds, their coming and going for the most part being involuntary.

When we think quickly, when ideas are grasped easily, and remembered readily, we experience a certain ease and pleasure in our mental life. When thought is slowed, and something seems to hold it back, we experience discomfort.

The rapidity with which our thoughts work varies greatly in different persons, and in the same person at different times. Under the influence of fatigue, hunger, insomnia, even a healthy brain is embarrassed by slowness and difficulty in thinking.

Certain disease-conditions show these variations in thought-action very conspicuously. For example, insane patients suffering from maniacal conditions present lively mental action, ideas crowd their minds rapidly, they feel exhilarated by the rapid flow of ideas, and a jolly, boisterous mood, subject to sudden changes, is common; while depressed cases, annoyed by difficulty in thinking, are made still more sad as they realize their inability to recall things, and to grasp easily the significance of various experiences that present themselves.

In addition to receiving impressions of things and from these impressions forming concepts, ideas, and judgments, ideas may

come to us in another way; that is, merely by *association*. For example, if we see a part of anything, we think of its whole; if we see an effect, we think of its cause, and *vice versa* — the one suggesting the other; then things are associated by similarity and by contrast, by the similarity of sound, etc. This is seen in the flight of ideas in manic cases — the sight of different things giving rise to a rapid flow of words, as the various associations are recognized; the tendency to rhyming in these cases is also because of this same *association of ideas*.

Under healthful conditions, any concrete idea remains in the consciousness but a short time, regardless of efforts of the will to hold it, being pushed aside by others and still others that keep forming; but under pathological or diseased conditions, where the normal association of ideas is hindered, a single concrete idea may remain in the consciousness with abnormal intensity and duration; this constitutes an *imperative idea*; and since our acts are the result of our ideas, ideas persistently held, however erroneous or absurd they may be, come in time to control our acts and to make up our characters. Absurd ideas may be judged as such by a person in the beginning of mental trouble, but as wrong thinking continues, he comes more and more under the influence of it, and in time loses his power to interpret things correctly.

All the sensations we experience become a part of ourselves — our *egos*. Each person is made up of a bundle of experiences. No two persons can be alike because no two have experienced just the same things in just the same way. Each differs from another because of different combinations and the different intensity and variety of concepts that have combined to form his ego.

When the brain is properly nourished, and is in good working order, then the impressions that come from the world outside are received, responded to, and judged in a normal and adequate way. But when a disease-process is set up, the brain does not work naturally; it is set going by stimuli from within as well as from without, and the patient finds himself in changed relations with the outside world; his power of seeing clearly and of judging wisely is therefore interfered with.

*Insanity* has been described as an alteration of the ego. Some-

thing has happened to the brain to hinder its normal function, so the affected person does not respond as before to outside influences, and the inner stimuli come more and more to dominate him. The perceptions, ideas, feelings, and impulses which arise (just as real to him as though they were reactions from external sense impressions) are really from excitations arising within. So we call him *alienated*. His inner world is out of harmony with the outer world. He is foreign to his normal self because his cortical cells fail to act as they normally did. These changed relations make him an *alien*. (You can now see why physicians who make a special study of mental diseases are called *alienists*.) When mental disturbances first appear, the patient is often able to recognize that his mental processes are not working normally; then we say he has *insight*; but as the condition progresses, and the consciousness becomes more disturbed, the patient is unable to distinguish between the stimuli which come to him from within and without, and so he responds as promptly to one as to the other. In auditory hallucinations, for example, he replies to our speech to him and to "the voices" in his inner consciousness with equal promptness. But if the hallucinatory state gets still more pronounced, the inner stimuli predominate, and he reacts more and more to "the voices," and grows correspondingly indifferent to external impressions.

*Disturbances in the emotional field* are usually the first abnormal mental symptoms to become apparent. A person may show marked emotion without sufficient motive, or may have an adequate cause for a given emotion, but may respond in such an exaggerated way that we call his response abnormal. Or he may show perverted emotion — the opposite to what one normally experiences under like conditions.

As we come to study states of exaltation and depression, we see that they are only exaggerations of normal psychic experiences. We know if we stop to think that there is a very wide range to the emotions that normal persons may experience. We feel surprise, shame, care, and worry, or we feel pleasure, joy, and even wild delight. These extremes may lie within the realm of normal experience, or they may escape these bounds and become pathological conditions.

The expression of the normal emotions and of pathological ones is the same, differing only in degree. Painful thoughts and feelings show themselves in a normally depressed person very similarly to the way they do in the pathologically depressed one; but aside from the degree of expression there is another very important thing to be considered. The normally depressed person feels pain and sadness from adequate cause; the emotions are the result of conditions that naturally cause pain and sadness, while the pathologically depressed person suffers from insufficient external cause, consequently as a result of inner processes.

Or, if an adequate cause started the depression, the manifestations may reach an abnormal degree; we so regard them when the person magnifies the causes, and when he is unable to let the healing forces of nature, hope, and time do their work, as they ordinarily do in normal persons overtaken by depressing factors. When introspection, self-accusation, and lamentations go from the normal into the realm of the morbid, we call the person insane in the emotional field.

Likewise in states of exaltation. We feel exhilarated from a brisk walk on a clear, cold night; the exhilaration shows itself in face, voice, gesture, almost like a mild intoxication; or we show gladness and even unbounded joy at some rare good news; still there are limits to the bounds of our extravagant expressions. But the abnormal person cannot control his exhilaration; he passes beyond the limits of propriety and decency; again we call him insane.

Children have not learned to govern their emotions. A child, in going out into the fresh air and sunlight, dances and skips with joy, thus reacting to these external stimuli regardless of the presence of his slow, sober-going elders. We, under the same conditions, feeling perhaps the exhilaration, react by a statement as to its being a glorious day, or we fill our lungs a little deeper, and perhaps walk with a sprightlier step; but we have become so hemmed about with custom, so used to repression, that we permit ourselves no other expression of the pleasure we feel.

The insane person is like the child. Impressions that come to him from within or without meet with uncontrollable mani-



festation. Hence the extravagance and often incongruity of his actions, especially in certain types of insanity.

The *genius*, too, is like the child in that his responses are keen; he feels things to a degree that less sensitively organized and better-controlled persons (that is, persons able to repress their feelings) do not. He sees things, too, in new relations. He gets called eccentric and sometimes foolish because he does not preserve the manner of mediocrity; but it is just because he is gifted with a vision withheld from ordinary mortals that he is enabled to bless the slow-going "normal" individual with the materialized vision which the normal man, though having eyes, sees not until it is materialized. So through geniuses we get the world's best paintings and sculpture, poems, music, inventions, discoveries.

There are other types near to geniuses, but lacking the divine fire, the individuals of which, like geniuses, have an unusual association of ideas — things strike them in original ways, they see them in the light that never was on land or sea, and often because of their ability to see commonplace things in an unusual light, they develop ideas that are really of value. Such persons are prone to dream of revolutionizing the race, but lack the ability to do as well as to dream; they are unbalanced, one-sided, and their visions are likely to come to naught just because of this want of balance; some others, of a similar make-up, but with more executive ability, found sects, start revolutions, and swell the ranks of fanatical reformers. The tendency of these eccentric persons to hold to their ideas, however unusual and absurd, till everything is colored and distorted by them, shows them to belong to the type from which we get our so-called cases of paranoia.

*Dreams* furnish a means for helping us to understand the abnormal working of the mind in insanity, because in both these conditions ideas and sense impressions occur mostly from inner excitation, dependent upon some changes in the blood, instead of from external influences. Therefore the ideas that arise do not correspond to reality; yet, since the power to judge correctly is in abeyance, the various ideas come and assert themselves, however incongruous they may be; and because



of the disturbance in the association of ideas, ideas elbow each other in a helter-skelter way, without the dreamer, or the insane person, as the case may be, being able to detect the mental disorder.

We know how in dreams the most improbable and contradictory things happen without causing surprise, and it is only when we start to relate the dream that we note certain discrepancies and incongruities. This may help us to understand the usual inability of the insane person to recognize the absurdity of his false beliefs, or to be reasoned out of them. But, as I have said, some insane patients have insight. Just as in our dreams we occasionally note an improbability and think, "This must be a dream," but go on dreaming, so the insane may have fleeting insight, or more permanent insight, as the case may be; again they are sometimes able to recognize their hallucinations and delusions as such, and anon mistake the inner for the outer stimuli. In dreams our powers of deduction and judgment are temporarily in abeyance, while in the insane they are disturbed to a more marked and a more or less permanent degree.

During convalescence from insanity the scales may drop suddenly from the mental vision, but more often the return to the normal is gradual. Delusions hang over like dream pictures, even when the patient seems nearly rational, and he is for some time in that hazy state of being unable to distinguish between the real and the imaginary. This readjustment to normal mental life is usually painful; the mental changes necessary to recognize and correct the false impressions are often tediously made, and the struggle between the fantastic and the real has to be gone through with alone. "Therein the patient must minister to herself."

When we say that *insanity is a modification of the personality*, it does not mean that the one so affected becomes another individual. He keeps, of course, his same body and brain, but certain minute changes have taken place; his physical and psychical life have undergone changes, although the changes are usually along the same lines that characterized the person in his normal mental state. In other words, his abnormal mental condition is largely an exaggeration of his tendencies

and predilections in the normal. Previous faults of character and of temper manifest themselves in greater intensity now. The sloth that was one of the besetting sins, the selfishness, the obstinacy, the uncontrollable temper, or the suspicious nature — these manifest themselves in greater proportions than formerly, dominating the mentality. In those who are of gentle disposition we often see gentleness degenerated into weakness and fatuousness; those inclined to sadness develop the profound depressions; those given to magnifying every ailment become victims of hypochondria. The person with a so-called natural intolerance for pain, who frets and storms till the family or the doctor do something to relieve it, who is impatient of delays and cannot brook anything less than immediate palliation, is of the type that needs to guard especially against becoming an alcoholic or a drug habitué. The fates of these self-indulgent natures who fly to drugs and stimulants for relief from pain and *ennui*, and so become their victims, reminds us that “we must learn to do without our opium,” and, as George Eliot says, to endure pain, if need be, with “conscious, clear-eyed endurance.”

There is no standard of sanity and insanity. Certain beliefs and manifestations that would be madness if held by a person who has received a liberal education are simply the natural result of ignorance and credulity, or of false theology, or of low associations, in another. Each person has to be judged according to his race, class, family, educational, religious, and social standing. Many sane persons have delusions; that is, they hold false beliefs; but these are the result of insufficient teaching and training, and so we call them *sane delusions*. In the days of the Salem witchcraft the belief in witches was held by a large number of sane persons, and even to-day in certain rural districts of New York State there are whole communities where the people still believe in witches. Erroneous as are their views, we know they are not insane, they are merely ignorant. But if a person who has been liberally educated, who has had the advantages of travel and of intercourse with the best minds, through personal relations and through books, comes to express the belief that she is bewitched, that the doctors are casting a spell upon her, and that all sorts of tortures are being inflicted by unseen agencies,

we can readily see that she is suffering from an *insane delusion*. It is contrary to what she believed when her mind worked in a healthy way, and she has lost the power to recognize the fallacy of such an opinion.

Mental disorders assume a variety of forms, according to the character and extent of disturbance of the different mental functions; the trouble may be chiefly in disturbances in perception, giving rise to hallucinations and illusions, or in the intellectual sphere, giving rise to disturbances of memory, disturbances in the formation of ideas, of the train of thought, of the reasoning and judgment, of the rapidity of thought, or of the consciousness; or the difficulty may be in the emotional sphere; or it may be in disturbances of volition and action.

The human being is a very complex creature, made up of a complicated body in which all the organs and parts working together comprise the individual life. We cannot, as I have said, think of the body and mind as separate; they act and react upon each other too intimately to consider them apart except for convenience in speaking. When body and mind work in harmony, when the functions are properly performed, when the impressions that come to us from without, and the sensations that arise within, are correctly interpreted, that is health — health of body and health of mind. Of course there are variations within the limits of health; no one is perfectly sound in every part at all times, but we are governed by the predominating conditions in speaking of health or disease. When, however, there is a prolonged departure from the normal and harmonious workings of the various parts, disease exists, and we name the disease in accordance with whatever part bears the brunt of the disturbance, whether it be heart, lungs, stomach, intestines, muscles, blood vessels, nerves, or brain. Yet, let me repeat, we need to keep in mind that none of these parts works independently, and all are to varying degrees affected by disturbances in one another.

## CHAPTER XXIV

### MANIFESTATIONS AND ACCOMPANIMENTS OF INSANITY

BEFORE studying the more pronounced manifestations of insanity it will be well to consider briefly some of the commonly observed *signs of approaching mental trouble*. When these signs occur as unusual manifestations in a given person, and to such an extent that they become remarkable, we are justified in thinking them the result of on-coming disturbance in the mental sphere. They are chiefly as follows: insomnia, increased irritability, impulsive outbreaks with gradual or sudden loss of self-control, destruction of property, injury to self and others, defect in the power of attention, lessening of the purposeful will power, depression, exaltation, indifference, or maybe apathy, neglect of personal appearance, morbid self-centering, erotic outbreaks, indecencies, perversions, alterations in the esthetic and religious life, unfounded fears, and imperative ideas and impulses giving rise to forced actions. Tirelessness is a forerunner of mental breakdown in certain persons, while undue fatigue is significant in others.

It is not, of course, meant that all these symptoms are noted in any one case. The above enumeration includes premonitory symptoms of widely differing forms of mental trouble. They are grouped here that the student may learn what are some of the danger signals of mental disorders.

Broadly speaking, insanity may be spoken of as showing itself under four heads: (a) Disturbances in perception (causing hallucinations and illusions); (b) disturbances in elaborating what has been perceived, as shown in disturbances in the memory, in the formation of ideas, in the ability to reason and judge correctly, in the rapidity or slowness of thought, and in the consciousness; (c) disturbances of the emotions, and (d) disturbances of volition and action.

There are also certain accompaniments of these disturbances which we shall need to consider, such as changes in the sensory and motor functions, in the vaso-motor, trophic, and secretory processes, and in the vital functions.

In some cases disturbances in the emotions may be the predominating symptoms; in others, disturbances in the understanding, and in still others, disturbances in the will; and according as one or the other group predominates, we are enabled to classify the cases under the various accepted forms of insanity; but there are no sharp lines, and we find that disturbances in one part of the mentality of necessity affect the other parts more or less, and that we must abandon the old notion that a person is "insane only on one thing." We must not, however, make the mistake of thinking he has lost all his power of mental activity because some powers are especially disturbed. But we must understand that since all the mental functions are so intimately related, the entire mentality is altered when certain functions undergo disturbance. I have already, in Chapter XXIII, spoken of patients responding to inner stimuli while misinterpreting them as stimuli from without. These are disturbances in *perception*. Such responses are due to deceptions of the senses, and are, as has been said, called *hallucinations*. How can these hallucinations take place? How can one, for example, hear talking when no voice within his hearing is really audible? In order to understand how, we need to keep in mind that all sensory impressions, when once stamped upon the brain centers, are capable of being re-collected, and that there is what is called a *sensory memory*. By means of this, under certain abnormal conditions, the faculty which ordinarily causes sensory reactions only to *peripheral* stimulation may cause those reactions *without* peripheral stimulation. Because the ear has become accustomed to hearing voices and the brain centers have registered these sounds, and the intelligence has translated them into words conveying ideas, and the memory has stored up these sensations with the resulting conclusions concerning them — because of all these stages, it is possible, in abnormal conditions, to have the senses cheated into seeming to sense things which they do not sense, and the person, we say, is the victim of sense deceptions — hallucinations and illusions.



Hallucinations may take place in any of the senses — hearing, seeing, smelling, tasting, and touch, so that the person affected hears, sees, smells, tastes, and feels things which have no external objects to evoke them, and yet so vivid is the impression made upon him, because of some abnormal excitation in his brain cells that are ordinarily only excited by real objects, that he feels certain that the things heard, seen, etc., really exist in the world outside, though in truth they originate in his own brain. He hears some one, for example, say, "He is going insane," when no voice within hearing distance has been raised. Auditory hallucinations are, as a rule, the seemingly audible expressions of the person's own thoughts; dwelling on them increases them.

Hallucinations may arise in sane persons from solitary confinement, fasting, loss of sleep, and other exhausting conditions. If the hallucination be recognized as such, we call it a *sane hallucination*; if it cannot be recognized as such, it leads to a falsification of consciousness, and becomes an *insane hallucination*. In some instances patients can recognize them as at least very unusual, and so are often capable of concealing their existence for longer or shorter periods, as the case may be.

*Illusions* are also deceptions of the senses, but they have an outside object as a starting point. The patient really hears, sees, tastes something, but thinks it is other than it is. He misinterprets it. For example, he hears the escape of steam, and thinks it is some one hissing at him; an engine whistles, and he thinks it is the cry of his tortured child. His sense impressions are as correct as ever, but the judging power is at fault. Some persons may experience illusions, but by bringing closer investigations and judgment to bear on them are able to correct the false impressions; this, as a rule, the insane cannot do.

Both hallucinations and illusions, when believed in as real, give rise to false beliefs or *delusions*, of which more will be said when speaking of disturbances in elaborating what has been perceived.

*Hallucinations* of all the senses may occur at the same time, or there may be disturbances in only one or two or more fields. Those of sight and hearing are most frequently observed. As

a rule, the hallucinations of sight occur in acute insanity, and of hearing in chronic insanity. Visual are less grave than auditory hallucinations. Sometimes patients speak of hearing the words spoken in their heads, or abdomens, or close to the ear, or on their tongues, instead of in the outside world. Sometimes they speak of telegraphing or telephoning taking place in their brains. Hallucinations of smell and of taste are usually unpleasant in character; they are more common in the chronic than in the acute forms of insanity. Those of hearing and of sight may be agreeable, or the reverse. Unpleasant hallucinations often give rise to dangerous conduct on the part of their victim. Hallucinations of smell are often associated with disorders of the sexual sphere, and are found in many patients given to excesses and perversions. They are also seen in the toxic infections, in certain organic lesions, in hysteria, epilepsy, and other functional disorders. Hallucinations of taste are frequently found with delusions of poisoning—the patient imagines he tastes arsenic, copper, and the like, in his food.

It is difficult to distinguish between hallucinations and illusions of touch; real bodily sensations probably often give rise to the patient's belief that he is being tortured by unseen wires, covered with poison, molested by some one visiting him at night, and diverse complaints of this nature. These perversions of the common sensibility are spoken of as *somatic sense deceptions*.

Disturbances in elaborating what has been received in the mind through sense impressions depend largely upon the impairment of the memory. It is by means of the memory that we are able to recall former impressions and so form *concepts* or ideas of objects previously perceived. Memory is dependent upon three things: the vividness with which we are impressed with things presented to our minds, the power of retaining things presented, and the capacity to reproduce the impression. Anything which affects the normal reproduction of ideas affects the memory. The ideas may come so quickly into the mind that each one gets effaced because there are so many, or there may be conditions in which something interferes with the formation of memory pictures. In excited cases we see facilitated reproduction of ideas, so that things previously experi-

enced and things experienced at the present time crowd so close that a jumble of ideas results. Where there is interference with the reproduction of ideas, we get periods of loss of memory (*amnesia*) varying in degree from the slight loss due to mental fatigue, through all the gradations noted in the profound depressions, in hysteria, senile dementia, and general paresis.

In some instances the power of retaining new impressions is impaired; the patient cannot remember a name or number or color for half a minute. In the mental disorders due to old age we see lack of impressionability concerning things that are happening to the patient now, but with ability to recall events long past.

When the accuracy of memory is disturbed, we see the patient unconsciously distorting facts when telling them, or he may mix real experiences and imagined experiences together without knowing it, or may deal in fabrications which are really hallucinations of memory — the patient weaving an account of things often improbable and contradictory, that never existed, yet doing this all unconscious of the untruth. Hysterical patients will often give the most remarkable account of things they have done, which, all unknown to them, are untruths “out of whole cloth,” as the saying goes. An excess of the imaginative faculty in some children, as in hysterics, accounts for these confabulations.

When the disturbance is in the intellectual sphere, there may be abnormally slow thought, or abnormally rapid thought, giving rise, in the one case, to dearth of ideas and dearth of expression, with a depressed emotional state, and in the other case, to a rapid flow of ideas and a more and more jumbled way of expressing them as the disorder progresses; this latter condition being accompanied by an exalted emotional state. Sluggish thought and slow, halting speech, or no speech at all, is opposed, in the one condition, to rapidity of thought and full speech, with a flow of words increasing to a disconnected *flight of ideas*, till finally the association between the ideas can no longer be traced by the bystander. Such a stream of thought is called *incoherent*.

Other disturbances in the intellectual sphere are seen when troublesome and annoying ideas (imperative ideas), recognized

as absurd by the patient, are held in spite of all efforts to dismiss them. These come into the consciousness spontaneously, cropping out seemingly regardless of any association, and disturbing the regular train of thought. Such patients are miserable unless they yield to these persistent ideas. They must wash their hands so many times before touching anything, lest they contaminate it, must count so many times before undertaking a certain task, must step on a certain crack in the floor, or on a certain flower in the carpet, or they cannot get it out of their minds, as they say, and so are dominated by it.

When a person holds a belief that is false — a belief that has arisen because of some disturbance in his perceptions, and in his ability to correctly interpret them, and when he is unable to see the error of his false judgment, even when clearly pointed out to him, if this false belief is the result of disturbances in the structure or function of his brain cortex (and not from ignorance or superstition), we say he has an *insane delusion*.

Sometimes the conduct of others, wrongly interpreted, is the starting point for the wrong belief, sometimes bodily sensations, disturbances in some of the organs, cause the patient to build false beliefs upon them. For example, rheumatic twinges may be interpreted as pains from concealed wires applied to torture the patient, and sometimes false impressions received from the various senses come in time to be falsely judged by the patient.

Delusions may be depressive or exalted. Patients may feel themselves abused and persecuted, or they may falsely believe themselves to be very unworthy, or dead to the world, or possessed by demons, or they may believe that all their organs are turned to stone, or are otherwise incapable of performing their functions. These are all examples of *depressive delusions*. On the other hand, the false beliefs may take on an expansive character, and the patient believe himself to be some exalted personage, some earthly ruler, or some one in close touch with the Creator — Jesus, or the Virgin Mary, or if not these, at least one specially set apart for work of a divine character. Or one may think himself capable of great feats of bodily strength, of unprecedented mental vigor, of untold wealth, of marvelous inventive, artistic, or executive ability.



We speak of delusions as fixed or transient according as they are temporarily or constantly present in the consciousness.

An insane delusion cannot be persistently held except there is a grave disturbance of consciousness, making clearness of judgment impossible. It matters little what the patient believes, nor how many false beliefs he holds; the fact that he holds any one false belief and holds it persistently and is unable to correct it, shows him to be insane, even though many of his mental faculties appear to be in their usual working order.

There are various ways in which the consciousness of the patient may show disturbance: in excessive self-consciousness, in absent-mindedness, in difficulty in sensing his own consciousness, so that he regards himself as an external object, and speaks of himself in the third person, in inability to comprehend where and who he is, and what the year, the month, and the day are, who the persons are about him, and his relations to them and the external world in general (*disorientation*). Or certain other persons may have breaks in their consciousness; a given person may undergo a peculiar breaking up of the consciousness as a whole, some parts separating themselves from others in a way to make virtually two personalities instead of one, the patient becoming alternately one and then another personality, with no memory to bridge over the transition from the one to the other. A dual life is thus lived by one being, a Dr. Jekyll and Mr. Hyde existence. Or there may even be a breaking up into more than two personalities. Well-authenticated cases are on record where such multiple personalities inhabit the one body, the one individual in turn playing many parts, according as the different consciousnesses come to the surface. Cases of true hysteria come under this head of dual and multiple personalities. Other conditions in which consciousness is disturbed are seen in slight cloudiness, in dreamy states, in the stupor of epilepsy and of other conditions, in ecstasy, and in certain alcoholic psychoses.

We are wont to speak of *mental reduction* in connection with certain cases. By this we mean a loss of power of connected thought, a dulling of all the faculties, a loss of interest and emotion, a weakness of memory, falsification, and confusion of



ideas which give rise to imperfect grasp of matters pertaining to self and surroundings, and a diminution of the sense perceptions. When this is profound, we see the apathy and listlessness and the dearth of ideas — in short, the condition that we usually characterize as *terminal dementia*.

We have in disturbances in the emotional field abnormal feelings — feelings arising without sufficient cause, or, if with sufficient cause, out of proportion to the cause. There are abnormal painful emotions, and abnormal pleasurable ones. When the impressionability is too keen, the slightest causes give rise to exaggerated responses of either pleasure or pain, or adequate causes are responded to with emotions entirely out of proportion to the exciting cause. Laughter and weeping are too easily evoked, bodily pleasure or pain too keenly felt, the beautiful and the ugly give rise to extreme hypersensitiveness; objects and persons are too violently admired and adored, or disliked and abhorred; exaggerated sympathy for others is felt, and extravagant conceit or suffering, as the case may be, is experienced at compliments or reproofs. Or if, instead, there is emotional dullness, things ordinarily responded to are regarded with indifference — friends, work, obligations; the person's feelings are blunted; he may feel himself dead, or inhuman, or changed or unreal. He may lose his former esthetic feelings. He may respond in a perverse way to things that ordinarily would call forth an opposite kind of reaction. For example, the odor of a delicately scented flower may cause disgust, the sight of a former friend, hatred, while the patient may take delight in swallowing obnoxious substances, in tasting unclean things, in witnessing suffering, or in profaning objects hitherto held sacred.

Patients under the dominance of abnormally depressed moods are often capable of understanding their changed states, and suffer because they cannot suffer, as it were. They feel bad because they no longer suffer at being separated from their home and friends. Nothing seems real to them, nothing touches them intimately, or rouses them sufficiently to awaken the natural feelings, so they say they are changed and unreal — all sense of reality is lost in some persons; a wall or barrier looms up between them and everything.

In the face of exaggerated emotional tone it is difficult even for a sane person to judge correctly. In fact, the greatest proof of soundness of mind is one's ability to suspend belief in the presence of an exciting emotion — to weigh and judge correctly, dispassionately. Untutored minds cannot do this, prejudiced minds cannot, unsound minds cannot. Emotion and imagination sweep away reason. The person under their sway believes because he is stirred, moved, and wants to believe, not because his highest power — the judging faculty — coerces him to believe. The intensity of one's belief is no proof of its truth, except to the misguided believer. The fire of the moment, the emotion, burns up all else, so that only the emotion seems the reality. This intense emotion is accompanied by a bodily commotion; the person thinks, "Nothing which I feel like *this* can be false." Most supernatural beliefs come about in this way; persons prone to succumb to them are seized with a mental vertigo that prohibits the exercise of their judging faculty. This is the type of mind that makes possible the fanatic and the mystic. Of such unstable types are mobs created, and from this uncritical way of regarding things arise the impulsive crimes that shock society — reason in abeyance, emotion in the ascendancy. Given these conditions, the results are only a question of degree, and depend upon the experiences and environment of a given individual, and the trend that his emotions take. They are alike in kind; they differ only in degree; reason is dethroned; emotion is the usurper; indiscriminating and ill-regulated conduct must follow.

In observing the manifestations of abnormal emotional states, we need to remember that feelings of agreeableness or disagreeableness are quickly reflected in the brow and eyelids. Form a habit of studying these reactions in the sane as well as in the insane. In self-satisfaction and in self-debasement how opposite the facial expression and carriage of the body! In the one all is expansion, in the other all is contraction. In the one the person obtrudes himself upon the notice of all; in the other he crouches and shrinks from observation.

In diseased conditions where the impulses and the will suffer chiefly, we get unnatural and irrational acts as a result. The

appetite for food, the sexual instinct, self-preservation, and other normal instincts, undergo change. The appetites may be increased or lessened or perverted. Patients may eat voraciously, or refuse food, or eat disgusting things. In the sexual field this is seen in excesses, in unwonted abstinence, or in indulgence in self-abuse or in still more abnormal practices, such as perversions with the opposite sex or with the same sex. Or there may be apparent absence of ordinary healthy sexuality, and the abnormal sexual feeling may show itself in undue coquetry, exaggerated attention to personal adornment, inordinate use of perfumes and pomades, suspicion concerning the virtue of others, constant conversation about marriages, scandals, and sexual topics, harping on symptoms referable to the pelvic organs, or in excessive religious observances; these are all considered sexual equivalents, manifestations of the extent to which the disordered sexual instinct is influencing the life.

*Impulsive acts* are those which result without the ideas which give rise to them being clearly defined in the consciousness; therefore we say of such acts that they are without motive and are incomprehensible. These are common in cases of arrested development, as in idiots and imbeciles; in hysterics, epileptics, and persons crazed by drinks; in organic brain diseases, and in excited and depressed cases where the governing power of the individual is no longer capable of exerting its customary restraint. In these impulsive outbreaks the thought is immediately translated into an act without the intervention of the will.

Maniacal persons "do the first thing that comes into their heads," regardless of consequences. Depressed patients often make agitated, restless, perhaps absurd motions, which are really reflex movements set going by the painful feelings and the abnormal workings of their brains. Demented patients strike themselves, pull things to pieces, rub off their hair, pull it out, walk in one place habitually, or perform other stereotyped movements that are automatic, that have come to be muscular habits uninfluenced by the will.

Other disorders affecting the will are those of abnormally increased and abnormally lessened will power, resulting in the

one case in obstinacy, in the other in powerlessness to determine a course of action and hold to it.

The insane present disturbances in speech varying with the different psychic conditions already described. There may be increase in the rapidity of speech, from merely a rapid flow to actual incoherence, or the speech may be slow and stuttering; or there may be *mutism* (not deaf-mutism, but a condition of being mute dependent solely upon disturbance of the mental life); there may be inability to say certain words, or to put the right word in the right place (*aphasia*); there may be silly affected speech, baby talk, senseless jargon, and gibberish, or wearisome repetition of a word or a phrase (*verbigeration*), or coining of words to correspond to certain abnormal feelings that arise, or difficulty in pronouncing certain words, due to muscular weakness; for example, the slurring way in which patients with general paresis say "Round the rugged rocks the ragged rascal ran," and other test phrases put to them. Or there may be scanning speech. Unusual associations of words, rhyming, and the making of puns are also among the symptoms often noted.

Other manifestations of insanity are seen in disturbances of the sensory and motor functions, in vaso-motor, trophic, and secretory disorders, and in disturbances in the vital functions.

Under disturbances in the sensory functions we see conditions of *anesthesia* and *hyperesthesia* — certain parts show lessened sensation or loss of sensation to touch, to heat and cold, and to pain, or they may show increased sensation, so that the lightest touch gives rise to pain, and all cutaneous impressions come to them with increased force. Neuralgias may accompany insanity. Anesthesias are noted in hysterical and demented patients and in those suffering from organic nervous diseases. Patients undergoing mental reduction show a dulling of their sensations; they are often inattentive to heat and cold, indifferent to the taking of food, and to evacuating the bowels and the bladder. Certain deteriorated patients will stand against a hot radiator or put their hands in hot water with apparent obliviousness to the burns and scalds that are sure to result unless such are carefully safeguarded. The self-mutilations noted in certain deteriorated cases is due to this want of normal sensation.

Localized areas of anesthesia as to pain, touch, and temperature are seen in hysterics, and in patients suffering from organic lesions of the central nervous system, in general paresis, and senile and alcoholic cases. When patients are anesthetic they often burn or maltreat themselves severely; when they are hyperesthetic they cannot endure even the gentlest handling of the affected parts.

Motor expressions of insanity are seen in the various facial expressions, carriage and posture of body, station, gait, the altered reflexes, in tremors, spasms, convulsions, choreic movements, tics, paralyses, contractures, and failure of coördination of the muscles. To illustrate a few of these motor expressions we need only to recall the troubled, wrinkled face of the melancholy patient, the changing vivacity of the maniacal one, the proud bearing and supercilious expression of the patient with grandiose delusions, the swimming eyes and the too ready smile of the hysteric, the careless gait, fatuous smile, and generally dilapidated appearance of deteriorated patients, and the wandering, perplexed air and restless dissatisfaction of senility.

Disturbances of the deep reflexes are found in melancholiacs, in anemic persons, in general paretics, in senile patients, in epileptics, and in persons with dementia præcox. The knee jerks are usually sluggish in depressive forms of insanity, and exaggerated in manias, exhaustion cases, and in dementia præcox. The absence of eye reflexes, the failure to react to light, in most instances indicates some organic brain disease. Exaggerated superficial or skin reflexes are common in hysterical and neurasthenic patients.

Lack of innervation of the facial muscles is seen in the irregular movements around the corners of the mouth and the eyes, irregular wrinkling of the forehead, etc. Alcoholic cases, general paretics, and terminal dementals furnish examples of these movements. Tremors are of various kinds and may indicate many and diverse conditions. They may be the result of anxiety, fear, or other nervous excitement, may be dependent upon anemic states, or they may indicate alcoholism, general paresis, or sclerotic brain affections. Convulsions may affect single muscles, an entire limb, or they may be general. When coming



on for the first time in middle life, they usually indicate advancing organic brain disease.

Disturbances in the articulation due to motor states are noted in alcoholism, general paresis, syphilis, and other grave conditions.

Muscular incoördination is seen in alcoholism, in general paresis after apoplexies and injuries, in brain tumors, etc.

Stereotyped attitudes and movements are common to a large number of the insane. These may be of some part of the face, of the limbs, of the voice or speech, of the carriage, posture, or gait — in fact, since the basis of stereotyped movements is to be found in common, everyday acts, the movements themselves are correspondingly varied. Among some of these movements are the following: screwing up one eye, pursing out the mouth, chewing the tongue, lifting the skin of one half of the forehead, blowing out the cheeks, swallowing air, holding the head forward in turtle fashion, rubbing a part of the body automatically, making peculiar meaningless gestures and motions with the arms and hands, swaying the body rhythmically, speaking in a high-pitched or otherwise affected voice, prefacing certain words with queer guttural sounds, or whisperings — these are only a few of the innumerable stereotyped ways you may note in long-standing deteriorated cases. These movements probably started as the result of some insane idea, and were consequently voluntary, but have persisted so long that they have become automatic, and in most cases the idea that gave rise to them has probably ceased to appear in the consciousness of the patient. We call these peculiar stereotyped movements *mannerisms*.

Another condition associated with impairment of the volitional sphere is *negativism*. This may be of only a mild degree, or may be very extreme. It may show itself in a patient's keeping his eyes closed, in turning away the head when spoken to, in walking or drawing away the minute he is approached, in creeping out of sight, in refusing to eat, or to void urine or feces for long periods; in short, in responding in just the opposite to the natural way to the various stimuli offered.

Mention has already been made of *imperative ideas* coming into the consciousness and dominating everything, even when

the patient is capable of recognizing the absurdity of them. Out of these imperative ideas, or *obsessions*, grow imperative acts. Certain suicidal attempts and homicidal attacks come under this head, but certain others are the outcome of deliberation.

*Vaso-motor manifestations* are frequently the direct result of emotions; among these we see the temporary palings and flushings, blueness and swelling of parts, skin-writing, disorders in the pulse, pain, pressure, and anxiety referable to the heart, with palpitation and *globus hystericus*, or a feeling of a ball in the throat. *Trophic disorders* are often an accompaniment of insanity. By these we mean disturbances in the nutrition of a part. This may have taken place during development in the uterus, or later in life. The malformations of the bones and soft parts that persons are born with come under the head of trophic disorders, such as a lack of symmetry in the bones of the face, head, or other parts, poorly placed and irregular teeth, harelip, cleft-palate, imperfectly formed ears, hypertrophy of parts, and other anomalies too numerous to mention. Some of the trophic disorders developing later are obesity, abnormal growth or loss of hair, pigmentations, bed sores, inflammations of joints, abnormal brittleness of bones, and trophic changes in skin and nails. Of course many of these conditions are also seen in persons who are not now and are not likely to be insane.

In regard to *altered secretions* to be noted among the insane, there are lessened secretions in depressed cases, as a rule, and increased secretions in excited cases. Acute cases naturally show more variations than chronic ones. Some depressed patients cry and moan and are consumed with grief, yet the secretion of tears is often very scanty, while in excited patients we see the bright glistening eyes due to active secretion, even though they do not overflow with tears; and in erotic cases it is no uncommon thing to see the swimming eyes that indicate exaggerated secretion.

Increased and decreased secretion of urine and of saliva are also noted. Manic cases in the height of their attacks are especially prone to the expectoration of saliva. Demented ones

may hold saliva in the mouth or let it dribble from the corners; this is not due to increased secretion, but rather to stupor and neglect to swallow, or, in some deluded patients, to delusions concerning the value of, or disposal of, the saliva. Depressed patients may have cessation of the menses, owing to anemia or other causes that reduce the nutrition, and the reestablishment of this function usually takes place when the physical health is sufficiently improved to admit of it. As a rule, it is not that the insanity causes the cessation of the menses, or the cessation of the menses that causes the insanity, but that both these symptoms are due to disorders of nutrition.

We need in the conclusion of this study of the manifestations of insanity to consider further how the *vital functions undergo changes* which are in part causes and in part accompaniments of insanity.

The *temperature*, as a rule, does not show conspicuous deviations from the normal, unless there are accompanying disturbances in the vegetative organs. Still, in certain congestive conditions—in epileptic attacks, in apoplectic seizures, in general paresis, in delirious cases, and in certain nervous states—we see increased temperature, while in advanced general paretics, and in stuporous cases, there is often subnormal temperature. The *pulse*, however, may show great variation, dependent upon the emotional changes as well as upon whatever bodily conditions may be present to affect it. The *respiration* is very variable, and is greatly influenced by the emotions. Agitated cases of depression may show very shallow and rapid breathing, stupid cases with dulled emotions, slow and insufficient respiration, and certain deluded persons controlled by false beliefs will try to hold their breaths as long as possible, and to breathe no deeper and no more frequently than they can possibly help. Such practices, if persisted in, favor the development of phthisis. Certain patients with an hysterical tendency frequently present remittent, jerky, and exaggerated respiration, largely voluntary; while others with organic brain disease show remittent and disturbed breathing of an involuntary nature.

*Digestion* and *assimilation* are often surprisingly good in mildly excited cases, while in the depressed these functions are usually

sluggishly performed. Likewise, the *general nutrition* is often above par in mildly excited cases, while in profoundly excited and in depressed patients, during the height of disease, the bodily weight is likely to be reduced, and improvement in the mental state is usually accompanied by improvement in nutrition also.

*Disorders of sleep* are common in the early stages of most mental troubles. Certain excited patients may go with little or no sleep for weeks without showing signs of exhaustion, although if proper care and nursing are given, such protracted insomnia is unnecessary. Depressed cases, especially of the agitated variety, sleep poorly. Because their sleep is unrefreshing, they believe that they have not slept at all, or they may assert that the sleep was not natural, but was the result of drugs, when such is not the case. Senile patients are especially prone to nightly restlessness. The majority of chronic patients sleep well, provided that they are hygienically cared for, with due attention paid to their evacuations, to their nourishment, cleanliness, bed coverings, and ventilation.

## CHAPTER XXV

### FORMS OF MENTAL DISEASE

At this stage of psychiatry when dissatisfaction concerning old classifications of mental diseases is so marked, yet when those who are making the most thorough and painstaking study of the various disease-types are loath to offer a new classification, it seems presumptuous to attempt a description of the various psychoses under any definite names — these names and these disease-types being still so fruitful a source of discussion and difference of opinion. In the study of mental diseases it is much more important to observe each case closely, and gather together the distinguishing facts concerning it, than it is to give it a name and compel it to come under that head, when perhaps it presents certain features that make it difficult to put it in any of the well-defined groups.

Fortunately the complicated questions that puzzle the psychiatrist need not disturb the nurse, and for her purposes I have thought it best to take up some of the commonly met and generally accepted forms of mental disease and briefly describe them, omitting the rarer forms and leaving the various considerations that puzzle the psychiatrist entirely out of the question.

**Exhaustion Delirium.** — A collapse delirium following some condition which has produced profound exhaustion may cause the patient to be sent to a hospital for mental diseases, although most of such cases pursue a rapid course (two or three weeks) and may be cared for at home. Exhaustion delirium frequently follows childbirth, severe loss of blood, excessive mental strain, and certain acute diseases, as pneumonia and the various infective fevers.

The principal symptoms in these cases are loss of sleep, followed by great restlessness and clouding of consciousness; the patient



does not know where she is, and does not recognize her friends; she has dreamy hallucinations, illusions, fears; the talk is incoherent, the delusions are likely to be changeable and of an exalted or a depressed character; impulsive acts of violence, immodest behavior, and unreasoning resistance are common manifestations. These are accompanied by weakness, greatly reduced nutrition, tremor, subnormal temperature, weak and irregular pulse, and usually exaggerated reflexes. The cloudiness of consciousness disappears suddenly as a rule, and as the physical condition improves the other mental symptoms subside.

More profound cases of mental confusion present similar symptoms, but run a much longer course — two or three months.

**Intoxication Psychoses.** — Intoxication psychoses are mental diseases due to the toxic effects of alcohol or drugs. The infection may be acute or chronic. The manifestations depend upon the quantity and character of the poison taken, upon the susceptibility of the one taking it, and upon the length of time he has indulged in the use of the poison. Alcohol, morphine, and cocaine are the toxic substances we shall consider here.

**Acute Alcoholism.** — Acute alcoholism at first makes its victim experience an unwonted sense of well-being; his mind works rather more quickly than usual; he becomes talkative, gay, and lively; he thinks he is being very funny and even witty, when perhaps he is uttering the most commonplace remarks, or reiterating the most fatuous statements. The emotions are very unstable in these cases; the person laughs, sometimes at the least little thing, weeps, or grows sentimental or maudlin, gets angry at the slightest cause, and becomes profane, obscene, abusive, threatening, and may be violent. At first he feels himself stronger than usual, often boasts of his great power or his intellectual ability, his high standing, his wealth. He loses all sense of decency and propriety. The exaggerated feeling of strength and well-being soon passes; his movements are poorly controlled; his conduct becomes more and more reckless; his smile a besotted grin; his speech thick; his intellect more and more dulled; his gait staggering; and a temporary paralysis

may supervene, the person becoming insensible and unconscious. After sleep he awakens with headache, weakness, nausea, and loss of appetite.

**Chronic Alcoholism.** — Chronic alcoholism shows itself in gradual and progressive mental deterioration and in certain physical changes that show the deplorable effects of the poison on the central nervous system and on the bodily organs and functions.

Persons so afflicted are poorly equipped with power of resistance, either because of defective hereditary endowment, or because factors in their early development have rendered them unduly susceptible to toxic substances, so that they are profoundly affected by an amount that would only cause a mild exhilaration in a more stable organization. For such unstable persons there can be no half-way course. They cannot be temperate. They must be total abstainers, or else must suffer the slow physical and mental deterioration that alcohol inevitably produces in such individuals.

Lessening of the moral sense is one of the most conspicuous features. The person gradually undergoes a change in character, he becomes untruthful, loses his finer sense of honor, little by little grows lax about things concerning which he was formerly most particular; his ideals dwindle; he sees those depending upon him suffering want and shame, yet pursues his downward course, seemingly indifferent to their needs or their entreaties. Sometimes he falls so low that he will pawn the clothing and food his wife has earned, in order that he may procure money to buy another drink.

The mental enfeeblement is slow but progressive. At first the person feels unable to apply himself to the tasks he formerly did with ease; his mind wanders; he has a growing sense of fatigue; later he shows impairment of judgment, poverty of ideas, and gradual failure of memory. As the condition progresses he may develop delusions of a persecutory nature. Along with the above symptoms muscular weakness is apparent; a fine tremor may come to be a pretty constant symptom; frequent headaches, dizziness, difficulties in speech and gait, are common, and convulsive seizures of an epileptoid character may appear.

**Delirium Tremens.** — Delirium tremens is an alcoholic psy-

chosis marked by the development of hallucinations, chiefly of sight and hearing, by fleeting delusions, chiefly of fear, and often by clouding of consciousness. This disease sometimes develops when the patient has had no alcohol for several weeks; in other cases when the patient first abstains, in others when he is still drinking. It is usually preceded by loss of appetite, vomiting and gastric pains, insomnia, restlessness, fear, bright spots before the eyes, and occasional hallucinations at night. As the disease develops, the hallucinations become prominent; first annoying, then terrifying. All sorts of animals are seen coming nearer and nearer — bugs, rats, snakes, or strange fantastic creatures, grotesque faces peer at him; devils mock him; an army seems to be advancing upon him, mobs revile him, he hears himself called vile names by his acquaintances, and taunted with all sorts of things.

It is only rarely that the hallucinations and illusions take on a pleasing character, but occasionally the patient thinks God appears to him and commands him to do some great deed, or he may hear beautiful music, or see lascivious visions. Later these false perceptions become fewer and less prominent, and the patient is able to recognize them as hallucinations and illusions, after which they cease to trouble him and soon disappear. As a rule the patient only half comprehends where he is; everything is interpreted in a confused and contradictory way; the time-sense is much interfered with, while the memory for recent events is very poor. Sleeplessness is a common symptom. The nutrition is very poor and, as in the other alcoholic states, gastric symptoms are prominent. The disease may last only a few days, or from two to three weeks. A few hallucinations may hang over for some time, but having acquired insight concerning them, the patient is no longer annoyed by them.

**Alcoholic Delusional Insanity.** — Alcoholic delusional insanity is recognized by the sudden development of delusions of persecution, which are based upon hallucinations of hearing. In this disease the patient retains a clear consciousness. The trouble comes on with nightly aggravations, the patient hears people shouting, crying, perhaps hears bells ringing, or reports of firearms. Later the shouting seems to refer more particu-

larly to him; he hears his name called, thinks his fellow-workmen or his cronies are in the next room talking about him; hears references to past shortcomings, or accusations concerning things he never did. He may hear persons saying that his wife is unfaithful to him, or that he and his children are to be maltreated or murdered. He may experience hallucinations and illusions of sight, also, especially at night, see flashes or spots of light, grotesque faces, creeping and crawling animals, and so on. In some of these cases hallucinations of smell and taste are also met.

The patient suffers horribly in this disease. He feels himself the unpopular center of attraction. He thinks he is being watched, followed, jeered at, about to be arrested, executed, or murdered. Sometimes in his terror of imaginary persecutors he goes and implores the protection of the police, believing that malefactors are hot upon his track, and in this act his insanity is first suspected. For these cases appear rational, they apprehend clearly all that is really happening around them, can talk coherently, and it is only when investigation proves that their fears are unfounded, that their real state of mind is discovered.

This disease may run a short or an extended course — from two to three weeks in acute cases, or from two to ten months in protracted ones.

Some cases of chronic alcoholism develop delusions of jealousy, independent of the persecutory ideas above mentioned. A man so affected gradually comes to suspect his wife of infidelity, and every chance look or move that she makes is regarded as proof of her guilt. Even her interest in her own father or brother may be misinterpreted by him as proof of the depth of degradation to which she has fallen; the flicker of a light, the rattle of a shutter, a glance out of the window — all are interpreted as signals and secret messages between her and others. If hallucinations of taste are experienced, he comes to believe that his wife or others are tampering with his food to poison him.

In these cases, as in the foregoing, the consciousness is clear, and, to a casual observer, but little beyond irritability and unstable emotions are noted; and these may be attributed to what seem to be the patient's just cause for complaint. It often happens that the patient sets forth his suspicions and his reasoning



with circumstantial details, so convincingly that he succeeds in leading really astute persons to believe him to be a much-wronged and long-suffering husband. Suffer he assuredly does, for it is as real to him as though it were all true, and his genuine emotions together with what seems to be indisputable proof (as he tells the story) often lead others to harbor most unjust suspicions of the woman he accuses. She, in turn, may not know of his suspicions, or, if she does, may be too proud to let his insane conduct be known, or may not even realize that it is insane, yet, seeing her inability to convince him of her innocence, she may suffer in silence all sorts of abuse and threats and accusations at his hands. Many a wife will face repeated danger to herself from a husband so insanely jealous, and only ask for protection if his threats or acts make her fear for her children's safety. It is not at all uncommon for these patients to continue living on affectionate terms with their wives while accusing them of continuing in their adulterous conduct. Other patients suffer so from their false beliefs that they attempt their own lives and sometimes those of their wives and the supposed paramours. Removal from home scenes is usually followed in time by an apparent disappearance of the delusions; but indulgence in alcohol, visits from friends, or return home are likely to be followed by a return of the delusions.

**Morphinism.** — Morphinism is the name given to the physical and mental deterioration caused by indulgence in the use of morphine. The victims of this drug are often to be found among physicians, physicians' wives, nurses, and others who, because of their intolerance of pain, have sought relief in this way until the habit has been imperceptibly acquired.

The first effect of morphine is to make one think quickly and clearly, but this soon passes away and a dreamy state supervenes, with numerous changing and fantastic hallucinations and illusions; this is followed by a slowing of all the mental processes, and a quiescent state in which the patient lives and breathes, but seems to experience a temporary suspension of all thought and feeling. In some cases these pleasurable effects are not experienced, and in their stead, headache, nausea, colic, and other uncomfortable symptoms are felt.



Persons who continue the use of morphine fail to get the acute effects, but they are held in its power because of its ability to exhilarate them temporarily enough to make them forget their troubles. They find to their dismay, however, that in order to get this result they must increase the quantity of the drug, and repeat it oftener; and only when the expense has to be reckoned with or the difficulties of administration, do they begin to realize to what a tyrant they have become enchained.

In most victims of this drug memory shows impairment, and the ability to apply one's self to physical or mental work is distinctly lessened.

The stability of the emotions is conspicuously affected; persons indulging in morphine are easily dejected and irritated. Anxiety, especially at night, is often experienced. They are sometimes very stolid, again show very unstable emotions.

The moral nature undergoes grave changes, even more grave than in alcoholism. Patients will resort to almost any measures to procure the means for buying the drug. They reach a point where they lie unblushingly. They grow more and more indifferent to work, friends, personal appearance, or consequences. They sleep or day-dream by day and grow restless and active as night comes on, often reading or otherwise occupying themselves all night long to the annoyance of the rest of the household. If one ventures to suggest that they do differently, anger and obstinacy are easily aroused.

These patients often complain of numbness, or hypersensitiveness; their pupils are usually contracted, their gaze is often furtive or staring; they are usually pale, with marked pallor of lips and ears. Some of them get hypochondriacal; some become weak and tremulous, lose flesh, suffer from dizziness, fainting spells, profuse perspiration, palpitation. The appetite may suffer, especially concerning meat; again there may be a ravenous appetite, and excessive thirst. Diarrhea and constipation are likely to alternate. Victims of morphine often become addicted to alcohol also.

*Abstinence symptoms* are those which appear on the withdrawal of the drug. These are tremor and uneasiness, tickling of the nose, sneezing, various peculiar sensations in different

parts of the body, obstinate sleeplessness, vomiting, diarrhea, perhaps hallucinations, twitchings, convulsions, palpitations, fainting, and maybe fatal collapse.

In favorable cases, as sleep and the appetite improve, the symptoms gradually disappear, but convalescence is slow.

Persons who have been addicted to morphine rarely recover permanently, though a few fortunate ones do. Relapses, and the tendency to resort to other drugs, must be guarded against.

**Cocainism.** — Cocainism is the condition of physical and mental enfeeblement due to the extended use of cocaine. Victims of this drug are quite likely to be addicted to morphine or alcohol also, and are usually persons of an unstable nervous system to begin with.

Cocaine mildly exhilarates at first, much as does alcohol; the patient becomes lively and talkative, and feels like undertaking things, feels increased mental and muscular power, but soon grows drowsy and inactive. Some persons are so susceptible to the drug that even small doses are followed by delirium and collapse. The patient grows pale and sickly looking, loses weight, acts sleepy, has no appetite; he may have twitchings, tremors, palpitation, fainting spells, and his sleep, poor as it is, may be disturbed by hallucinations, followed by delusions of a persecutory nature. These patients are prone to carry revolvers, as they believe it needful to be constantly on guard against attack. A characteristic symptom is a feeling as of something crawling under the skin.

Those who become addicted to the extended use of cocaine are in a pretty continuous state of excitement, but busy as they are, they seem incapable of applying themselves to any effective work. They show a deplorably weakened will, a steadily failing memory, and much misdirected energy. They are extremely loquacious, and are given to writing long letters or articles, and are prone to advance many impracticable schemes. Elation and depression frequently alternate. Suspicion develops, affection for friends diminishes, and they grow callous to all obligations and ties.

In chronic cases, hallucinations of the various senses may become distressing, especially those of sight and hearing. Black

specks before the eyes, visions thrown on the walls, threatening and insulting voices, a feeling of electricity being turned on, or of poison being thrown at one, are common experiences. These give rise to increased suspicion and suffering, and patients often grow to believe themselves the victim of deep-laid plots; they think themselves watched and followed, reviled, tortured, and perhaps about to be murdered or otherwise foully dealt with. Insane jealousy is a prominent symptom.

The insanity resulting from cocaine develops rapidly and usually runs a course of only a few weeks. It readily recurs on renewed indulgence in the drug.

**Dementia Præcox.** — A large group of cases is classed under the term *dementia præcox* — precocious dementia. The majority of these develop in early life, at the age of puberty, or in the adolescent period, and it is from these patients that the bulk of the chronic insane population in State hospitals is derived.

Persons with this disease present many and diverse symptoms, only a few of which can be indicated here. There is a strong tendency toward progressive deterioration in most instances, although a small per cent recover, and others show decided remissions of varying duration.

Physical stigmata are common accompaniments, such as malformed ears, high-arched and narrow palates, immature childish face and figure.

Among the physical symptoms most commonly noted are poor nutrition in the early stages (as deterioration becomes more marked many patients grow more and more stout), dermography, increased perspiration, cold mottled hands, dilated pupils, exaggerated knee jerks, and amenorrhea.

Persons who develop dementia præcox, as a rule, have a defective heredity, and furthermore have presented symptoms in early life that marked them as very different from their fellows — a tendency to keep by themselves, to be over-religious, to indulge in day-dreaming and immature philosophizing; often they are persons who have been addicted to the habit of self-abuse. A lack of application and a general inefficiency seem to have characterized their course in life.

Sometimes either an emotional shock, or exhaustion from some

acute disease, is the last straw, and the vagaries of the poorly balanced organization then rapidly become apparent. In other cases, the disease cannot be traced to any sufficient cause. Among the early manifestations may be an outburst of excitement and violence of an impulsive unreasoning nature. The patients are silly, often constrained and affected in manner; they express many absurd ideas, chiefly of a sexual and a religious nature. Their beliefs are likely to be mystical; they are inclined to attribute their morbid sensations and experiences to the influence of others who affect them in some occult way. The most improbable beliefs are held unquestioningly.

A conspicuous discrepancy in the emotions is observed. Silly laughter without any appreciable cause is frequently seen. Periods of unprovoked anger are common. They fly at the other patients, break furniture, destroy clothing, throw their trays, and so on, without any purpose back of their acts. These persons are apathetic in the performance of their accustomed tasks, indifferent to the sorrows of their friends, and often either irritably resistive, or provokingly unresponsive to all efforts made to awaken interest in things about them. Others may obey simple directions or requests, and many can be trained to do useful work in a routine way.

The memory of past events, especially of school knowledge, may be surprisingly good, even when the patient is very much deteriorated.

These patients may talk clearly and apprehend well their surroundings, or may seem unconscious of their whereabouts, or of the identity of their associates. They may speak only in monosyllables, or make irrelevant replies, or persistently refuse to speak for weeks and months at a time, giving the impression that they do not appreciate what is happening. Yet when this phase of the disease gives place to another, they may tell accurately much that happened during the period when they appeared oblivious to everything. They may talk and whisper to themselves by the hour, may be given to using stilted, high-sounding phrases, or to coining meaningless words. In conversation they sometimes show a disposition to trifle and deceive, and to express the most absurd beliefs, sometimes the most contradictory

ones, without being able to see the utter lack of sense in their talk.

There often seems to be some interference in the ability to think — some block in the way, also an inability to distinguish the real from the unreal. This gives rise to hazy, puzzled ways of looking at things, and our efforts at questioning are often met in a perplexed and evasive way. The same inefficiency is shown in action; the person does not easily plan and carry out things, but shows numerous evidences of purposeless unconsidered acts. If letters are written, they show extreme dilapidation of thought in many instances, or, if fairly sensible, they are full of fatuous expressions and repetitions.

Sometimes these patients evince a stealthy curiosity; again they may not attend to anything going on around them, but instead may stand for hours gazing at a spot in the ceiling, smiling ecstatically, listening to the "voices," or seeing visions. They take up, from time to time, many oddities, tricks of speech or action, senseless stereotyped motions or expressions. One patient, for example, will repeat for hours in a slow tone: "Don't say nothin', nothin', nothin'; don't say nothin', nothin', nothin'." Another will grunt or snort, or make chewing motions, or keep her mouth pursed up, or walk on a certain board on the floor, or assume certain constrained and awkward postures. These patients may be stubbornly resistive of everything done for them, then as unaccountably yield to persuasion in the most lamb-like way. They may refuse food for days; again will show a greediness more in keeping with a lower animal than a human being.

They often seem oblivious to their dearest friends, betraying no sign of consciousness of them beyond that of devouring food and dainties brought them. Their whole dress and bearing betray a dilapidation that is unpromising for mental restoration. Self-absorbed, unconcerned, apparently feeling neither joy nor sorrow, they often stare for hours into vacancy, wholly occupied with the hallucinations that are so prominent an accompaniment of this disease. Yet some of these patients show marked improvement, and some make recoveries, though their field of usefulness must remain very circumscribed, since their character is made up of such flimsy, flaccid material, and their impracticable schemes are so likely to come to naught.



**General Paresis of the Insane (Dementia Paralytica).** — The disease known as general paresis attacks persons in middle life, usually between the ages of thirty-five and forty-five. It is a hopeless disease, but there are prolonged remissions in certain cases. It is much more common in men than in women, and, although authorities vary in their views concerning its causation, it is coming to be pretty generally believed that syphilis and alcoholism, combined with physical and mental stress, are the chief and almost constant causative factors. The disease is on the increase. Most of its victims come from large cities — men who have been under long-continued physical and mental strain, indulging the while in sexual and other excesses.

It is a disease in which the definite organic changes that take place in the brain and spinal cord are accompanied by steadily progressing physical weakness, as well as by progressive mental deterioration; both of which processes in time go on to absolute paralysis and dementia. Sometimes the physical symptoms appear first, sometimes the mental; again they occur simultaneously. Some of the early symptoms most easily recognizable by an untrained observer are: irregularity of the pupils, headache, vertigo, and epileptiform or apoplectiform convulsions; or there may be extreme flushings, distended veins, great restlessness and irritability preceding the more marked manifestations of the disease. The countenance early undergoes a decided change; the lines of expression disappear, and a fine tremor is often seen about the eyes and lips, especially when the patient starts to speak. The tongue shows marked tremor; the voice becomes thick and monotonous, later very shaky; increasing difficulty in articulating certain sounds is noted, for example: "Truly rural," "Third riding artillery brigade," and "Round the rugged rocks the ragged rascal ran." A characteristic tremor and sprawliness is observed in the handwriting, and words are omitted unnoticed by the patient. These muscular weaknesses progress until the patient becomes totally disabled and bedridden. Some cases remain well nourished to the last; in others, where the nutrition becomes impaired, life drags on until the patient is a living skeleton, and bed sores may develop in spite of the utmost care, yet death may be weeks in coming

to his relief. In this stage, a distressing grating of the teeth is often kept up, adding to the general repulsiveness of the wretched creature.

The mental symptoms are extremely varied in different types, and at different stages in the disease. At the beginning patients may show a dullness of comprehension that resembles that of one stupid from alcoholic intoxication. This torpor increases as time goes on, but in some cases there are marked remissions, so much so that the friends are deceived into thinking that a recovery is taking place. Patients become very irritable in the early stages; a sudden outbreak of violence may be the first indication of aberration. The multitudinous extravagant and impracticable business ventures in one formerly astute in these matters are often the first indications that lead the friends to surmise that the man is insane. Unnecessary purchases may be the first signs noticed.

The memory becomes profoundly impaired, great deficiency in regard to time being especially prominent, particularly concerning recent events. Later, the memory for remote events suffers the same impairment.

The most conspicuous mental changes are noted in the astounding claims made by the patient. He is a veritable Munchausen — stronger than Samson; literally able to move mountains, capable of building a bridge to the moon; of reaching to the stars; he has a million wives, thousands of children; can create a bushel of diamonds a minute — these and other even more exaggerated claims of prowess and power being made by one who perhaps can scarcely articulate the words, and who is too feeble to convey a spoonful of food to his mouth. Although, as a rule, when physical disability becomes extreme, grandiose delusions are less in evidence, still some patients may be heard to mutter something about “millions” when speech is practically unintelligible.

Absurd ideas of strength and of grandeur seem less pronounced in women paretics than in men; still, their fantastic claims, when made at all, do not suffer those of the men to eclipse them; their husbands are legion; they have diamonds for eyes; their dress is the Cloth of Gold; each tooth is a pearl,

and if one should be extracted, they could cause another to spring up in its place; they will give you a thousand billion dollars, and will be equally munificent to any other person near by.

Two paretics will occasionally talk together, and each will try to outdo the other. Two railroad engineers, occupying neighboring beds, both cases of paresis, and both, as it happened, having the same surname, though not related, boasted as follows: One told that he was once making a certain run and ran the engine so fast that when she got in she was white-hot, whereupon the other told of a run that he made in which he ran so fast on a crooked road that the swinging of the engine put the headlight out. Then the first narrator told that he had just received a present of a ten-story marble palace, and the other followed with the statement that he had just received a diamond pin from his diamond mines in South Africa. But the other had picked up a diamond one foot in diameter on the battle field of the Boer War, just after a shell struck at his feet, and although it was shattered some, the pieces were so big he was using them yet.

The startling inaccuracies and discrepancies in the paretic's conversation are entirely overlooked by him, showing how profoundly impaired is his judgment. When you point them out to him, he fabricates still more to extricate himself.

The emotions are very unstable; the patient is at the mercy of any one who plays on them, and can easily be made to laugh or cry — a wavering expression, beginning as a smile, often changes to one of anxiety or grief, perhaps from so slight a stimulus as a frown or a sterner tone on the part of the interlocutor. A pathetic optimism is, however, seen in many cases, the patient replying that he feels "fine," or "first rate," when the disease has already made sad inroads in his physical and mental economy.

There are *four types* of cases, named, according to the predominating mental symptoms, as the demented, expansive, agitated, and depressed types. The *demented form* is most common. This runs a rapid course, as a rule, some cases dying within six months, and but few living more than three years. Delusions and hallucinations are common. The *expansive form* is the one in which fantastic delusions are so conspicuous. This runs a prolonged course, four to fifteen years, and often shows marked

remissions. The *agitated form* is rather sudden in onset, and usually terminates in less than two years. It is characterized by great motor excitement, grandiose delusions, and clouding of consciousness. The *depressed form* has many hypochondriacal and other depressive delusions; there may be clouding of consciousness and stuporous states. Most of such cases die within two years.

**Melancholia.** — The term melancholia has of late been restricted to a form of mental depression occurring during the period of involution. The age limits are usually given from forty to sixty. This and senile dementia are, therefore, spoken of as *involution psychoses*. There are other cases of depression, however, occurring earlier in life than the involution period, that were formerly classed as melancholia, and since these resemble the involution depressions very closely, they may, for practical purposes, be considered together.

Patients with melancholia suffer from profound depression and despondency; they are full of morbid fears and hypochondriacal delusions; of remorse for all the misdeeds of their past, whether trifling or grave in character. Their mental pain is extreme; they are not only tortured by the ills they have, but feel themselves about to be overwhelmed by others that they know not of. Some of these cases get well, others drift into a condition of chronic depression from which they cannot be aroused.

Persons who develop melancholia have in more than half the cases been weighted with a defective heredity. Some shock, grief, or unusual strain at this period of susceptibility serves to induce the outbreak.

The distinguishing features of this psychosis are exaggerated self-depreciation, despondency, a multitude of fears, delusions of a hypochondriacal nature, extreme worry, anxiety, and agitation, with perhaps moderate clouding of consciousness, and a tendency to dullness of the mental faculties, or to actual deterioration, after the disease has lasted for some time.

The first symptoms are usually those of bodily discomfort, headache, dizziness, pains around the heart, palpitation of the heart, poor appetite, and general debility. Some difficulty in

application is felt, later self-accusations appear; remorse for real or fancied misdeeds drives the patient to unending self-castigations. Doubtful acts in the past assume immense proportions, and the person suffers horribly from fears of on-coming punishment, which, however, he says is merited, therefore inevitable.

Such feel that they have sinned against the Holy Ghost; that it is wrong for them to eat, since by their act others must starve; that the weight of the world's woe rests on them; that the world is coming to an end, or is already at an end; some even declare that the earth is annihilated, the sun and stars are blotted out, that all creation has returned to darkness and chaos; that no one is alive, and that nothing is as it seems; that everything they think or say or do, or refrain from thinking, saying, or doing, brings fresh woe upon every one about them. Some horrible fate awaits them just around the corner; some overwhelming calamity is just about to engulf them and all they hold most dear.

The mental pain, nay, agony, of this class of cases is much greater than that of other depressions, *e.g.* that of manic-depressive insanity. The agitation and anxiety are much more pronounced; their self-torture is extreme, and the attempts at suicide may be many and persistent. These patients walk the floor, tear their hair, wring their hands, chew their nails, mutilate their skins, and moan or groan piteously, "I'm lost, I'm lost! what will become of me?" etc.

As a rule these patients retain consciousness of their environment, but their harrowing delusions are so insistent that they can harp only on one string — the misery that envelops them body and soul. Some cases are marked by even more pronounced fears and anxiety, and by actual clouding of consciousness.

It is often difficult to differentiate between melancholia and the depressed form of manic-depressive insanity. One needs to bear in mind the anxiety, agitation, and restlessness that characterize the melancholiac, and the slowness of thought, speech, and action of the manic-depressive patient.

In cases of melancholia that recover, a gain in weight is usually one of the first symptoms noted; the patients sleep better after a



time; show less apprehension; say less about their delusions; display a show of interest in their surroundings, and usually in the course of eighteen months or two years emerge from the cloud of blackness that encompassed them.

**Senile Insanity.** — Senile dementia is a disease of advanced life, as its name implies, occurring most frequently between the ages of sixty and seventy-five. It is progressive, leading to complete dementia and death. The duration may be only a few months, or it may last from three to five years. This is the form of insanity that the laity probably most frequently have reference to when they speak of “softening of the brain” — a term that has no place in the physician’s vocabulary, and which should be abandoned because of its vagueness and inaccuracy.

Heredity, shocks, and acute diseases play their customary part in the causation. Some families show a strong tendency to senile deterioration. In this, as in most other forms of insanity, the exciting cause of some bodily disease, or a shock, simply acts as the last straw to break the back of one already heavily burdened.

The varying forms of senile insanity are accompanied by hardening of the brain tissue and its blood vessels. Softened areas in certain parts are often found.

With some patients the manifestations of senile changes are so slight as to be unimportant, and scarcely to be distinguished from physiological senility — weakness of memory, childishness, reiteration of the same things, and inability to recall names and events of recent date. But when gaps in the memory are made good by fabrications; when delusions develop that the person is perhaps being purposely annoyed, cheated, robbed; when the patient evinces an unaccustomed indifference to the things that would formerly have moved him to joy or tears; when peevishness, perplexity, discontent, and unrest abound, then it is plainly to be seen that a true psychosis is established. The emotions become very unstable and shallow; the patient dozes through the day, and ransacks the house at night, rummaging aimlessly through chests and closets, often scolding and fault-finding, or even soundly abusing other members of the family. His former good habits in regard to eating, dressing, and attending to his

daily wants are neglected, and the condition is likely to progress until the patient becomes an unclean, unkempt, and a most pitiable object.

Aggravated cases have extreme clouding of consciousness; they do not know where they are; beg to be taken home when they are at home; may say they want to go to their mother's, and when asked where she is, answer, "In Ireland," and then start to walk there. They may fail to recognize the members of their family, yet greet as a hail-fellow the total stranger, calling him by the name of some friend, perhaps dead many years ago. They lose all account of time, cannot even distinguish day from night; will tell you that they are twenty-five or thirty, or "nearly forty" years of age in the course of one minute's conversation. Their own age being somewhere in the seventies, they will perhaps insist that their father is but fifty — "hale and hearty"; and the next minute will recollect that he died years ago. They make the most contradictory statements without detecting their errors, but when confronted by them usually promptly fabricate something which to them is an adequate explanation.

Some of these patients are quick at repartee and evasion; and, as though dimly realizing their inability to answer correctly, will "hedge" skillfully at the questions propounded. They "can't remember just for the minute," they "have an important engagement to keep and must not be detained," etc. One old lady who wandered off the ward, when brought back by the physician who found her aimlessly walking on the grounds, said, when questioned, that she "was looking for patches to mend that black dress."

Hallucinations of sight and hearing are common, also illusions. Every sound refers to the patient, chance passers-by are old friends; voices around her are calling her, and she must go and answer the summons. These poor creatures are extremely meddlesome and trying in a household. They will undo work that has been done, and pull beds to pieces to look for something that they are unable to name, even if they knew what it was when they started. They will putter with the fires, put sugar for salt in food, collect broom splints and other worthless objects and

hoard them in all sorts of places, eat soap, or other harmful and disgusting things, put on several sets of underwear, put their feet in their nightgown sleeves when trying to dress, and in countless ways demonstrate their utter confusion and inability to care for themselves, at the same time that they show the most stubborn resistance to being cared for by others.

By reason of their restlessness they become tremulous and exhausted. It is difficult to get their attention long enough to make them take sufficient nourishment, so intent are they in doing they know not what, and in going they know not where — the urgency for doing and going being the main thing.

There are all grades of senile dementia, from simple dotage to that of the delirious form, in which latter the patient suffers from imaginary sights and sounds, and from the false beliefs that result from these distressing symptoms.

The course of the disease is toward progressive deterioration. Apoplectic seizures may close the career; sometimes these are accompanied by hemiplegia, sometimes not. Milder cases should be cared for by the friends, but patients who become unmanageable, and sources of continual annoyance to the entire household, are properly committed to the State hospitals.

## CHAPTER XXVI

### FORMS OF MENTAL DISEASE (*Continued*)

**Manic-depressive Insanity.** — Manic-depressive insanity is the name given to a mental disease which recurs in definite forms, periodically, throughout the life of the individual, a typical case showing excited and depressed stages with normal periods between, and with little or no tendency to mental deterioration. It is the disease that was formerly spoken of as acute mania, the excited stage usually giving the name to the disorder, and the depressed stages slipping by as a rule without much account being taken of them; or, when noted, being considered as an entirely different disease, melancholia; or, if the excitement and depression, with a lucid period between, were so well marked in any one case as to compel them to be regarded as a distinct cycle, the disease was called *circular insanity*. These terms have now pretty generally given place to the term manic-depressive insanity, as this covers both phases of what is now considered one disease-process.

Typical cases of manic-depressive insanity present at some time in their career fairly well-marked phases of maniacal excitement, and again equally well-marked ones of morbid depression, with normal behavior between. But there are many cases where only the maniacal phases recur from time to time, and others where the depressed forms only are seen, and still others where a mixture of the two phases may be seen in one individual, in a single attack.

In the *maniacal type* there is great excitability and loquacity; mental and physical restlessness abound, with rapidly changing emotions; perhaps later, rambling, disjointed talk, rhyming, shouting, mischievousness, violence, disorder, and destructiveness.

In the *depressed type* the patient is dejected, undecided, and inactive, slow in speech and thought, with a tendency to become more and more sluggish in his mental and physical life, and often to develop delusions and hallucinations of a distressing character, and to show some clouding of consciousness. There are various degrees of the maniacal form. The mildest ones are called *hypomania*, more pronounced ones *mania*, and the most extreme are called *delirious mania*.

*Patients with hypomania* attract attention in their families by their almost ceaseless activity; they are regular chatterboxes; they are up early mornings stirring up things generally; they contrive to be very busy over the least little thing, and delight in getting into first one thing, then another, abandoning each as soon as they tire of it whether it is completed or not. Some develop great activity in letter writing, others in visiting their friends. The friends comment on how well they are looking and what good company they are, often without a suspicion that this increased activity and vivacity are the result of a morbidly excited nervous system. The handwriting usually shows exaggerated traits; it is executed rapidly with strong, bold strokes, much underlining and flourishing, and often with other ornamentation. If the excitement passes beyond the point described, the patient may show much exaggeration in voice, speech, manner, and dress, may affect bright colors, flowers, and perfumes, such manifestations perhaps being foreign to him in his normal state. In their talk, and especially in their letters, these patients change the subject frequently and abruptly, fail to finish various subjects that they start, and easily get switched off to talking on any subject that is suggested by what is happening around them. Self-esteem is prominent in these patients, and their own point of view, their own desires and projects are the only ones that they tolerate. They are the prey to their impulses, and while the mood is commonly cheerful and even exuberant, they become irritated on the slightest provocation, and are prone to indulge in detailed complaints and in angry and abusive talk. These attacks last from several weeks or months to a year or more, the patient gradually becoming normal just as he gradually became excited.



In the *distinctly maniacal condition* the patient presents more striking manifestations than in hypomania. His great excitability is shown in brilliant eyes, rapidly changing facial expression, smiles, winks, grimaces, ill-timed playfulness, boisterousness, and exaltation. His feeling of well-being is very pronounced, his mental and physical activities are very great. The sense of fatigue seems lost. He is constantly on the go, shows abnormal quickness of vision and hearing, but indifference to heat and cold, to hunger and pain. He is capricious in the extreme, yields to every impulse as does the hypomaniacal patient, but impulses are yielded to in quicker succession, making a jumbled emotional reaction. He may be witty, playful, jolly, and hilarious, but is as likely to be irritable, domineering, and violent. His outbreaks are usually short-lived. He is full of mischief, delights in playing pranks and in destroying things just for the sake of seeing the havoc he can make; he keeps his dress and hair in disorder, often decorates his person fantastically; is likely to be indecent in talk and behavior, and is given to showing the worst conduct before the opposite sex. At first, though talking excitedly, he may be able to keep to the point; but as the disease progresses, he is unable to hold to the topic of conversation; his mind wanders in the track of least resistance; so slight a thing as the jingling of keys, or the sight of a watch, will serve to distract him so that he weaves some reference to these things into his talk and is the prey of the countless impressions and sensations that come to him. This is called *distractibility*. The patient has lost his power of inhibition, and shows a tendency to act upon every impulse and idea that comes to him. Everything seems of equal importance, so he tries to comment on all of them, and as a result can make no coherent comments on any. One sound suggests a similar sound; he makes rhymes, puns, and revels in many word associations; he sings, dances, shouts, exposes his person, tears his clothes, destroys property, and grows more and more incapable of grasping and answering questions addressed to him — chiefly owing to the multitude of ideas that crowd his consciousness and efface each other before any of them can be expressed. Even when the case is not so extreme, and the patient is still

able to answer rationally and connectedly, there is a great inclination to trifle and to give consciously incorrect and "smart" answers, and to call persons by wrong names. Hallucinations and delusions are not common, although they may appear to be to a casual observer because the patient is so prone to make absurd boasts and exaggerated statements. Vague hallucinations of a very fleeting character may be present; illusions due to fluctuating attention are frequently noted. The faces and voices of strangers are interpreted as belonging to the friends at home. Some patients develop persecutory delusions for a time, which disappear ordinarily as the case clears up.

The physical symptoms are as follows: the pulse rate is usually quickened in proportion as the motor restlessness increases, and, as a rule, the blood pressure is low during excited periods, and the respiration accelerated but shallow. Marked variations in temperature are not established as being directly due to the excited state. The bodily weight nearly always decreases during maniacal periods. The pupils are usually widely dilated and react to light; the deep and superficial reflexes are generally increased. Digestive disturbances may be present. Many patients bolt their food, consuming enormous quantities (*bulimia*); others are too busy with their talk and their ceaseless motions to stop long enough to eat. The secretion of saliva is often increased, and during the height of attacks patients expectorate large quantities, taking malicious delight in defacing the walls, soiling the bedding, and using the faces of attendants as targets. Sleep is deficient, insomnia often extending over long periods without signs of exhaustion.

Manic cases are the ones that people in general are ready to admit are insane; this seems to be the condition that stands for insanity in the lay mind; the laity has great difficulty in recognizing more controlled forms as insanity. Many also refuse to consider hypomaniacal types as actually insane, simply because the patients have enough power to inhibit their talk and acts so as to keep fairly within bounds. Such eccentricities and annoyances as result from their abnormal condition are set down to meanness, malice, and total depravity, instead of being charitably judged as the manifestations of an abnormal mentality.

The evidence of a certain shrewdness common to such patients is seen, and it is wrongly concluded that because the person shows method in his madness he is not really mad, but only mean.

A defective heredity is responsible for the larger number of these cases. This form of mental disease often attacks persons who, though they may have been considered eccentric, because of temperamental instability, have been rather above the average in brightness and cleverness. Women between twenty and twenty-five years of age, predisposed to manic attacks, usually succumb suddenly after some bodily disease or mental shock, or later, during pregnancy, or at the time of, or soon after confinement.

Improvement, when it once starts, is usually rapid; the patient often recovers without recollecting what took place during the height of the attack. Others seem to remember well most of the happenings and experiences, but are loath to discuss them, being ashamed of what they remember to have said and done when unable to exercise self-control. Subsequent attacks may follow rapidly, or there may be intervals of several years between seizures, or, as has been said, a depressed attack may occur, and may alternate with the kind above described.

There remains to be described the delirious form of the maniacal type before considering the depressed form. *Delirious mania*, as has been said, is the gravest of the forms in the maniacal group. Here the consciousness is greatly clouded, the bodily and mental restlessness are intense, the speech is incoherent; distractibility is more pronounced even than in the preceding form; hallucinations of all the senses are numerous; changing delusions are prominent, and a dreamy, delirious condition supervenes. The patient rapidly shows the effects of intense excitement; nutrition becomes greatly reduced; a general tremulousness is seen; sleeplessness is persistent; the face becomes congested; the eyes are red, injected, and dull; the pulse becomes rapid and weak; perspiration is profuse. This form runs a rapid course, the height of the attack being reached usually within fourteen days, and the symptoms gradually disappearing in the course of a few weeks. If exhaustion or infection enter into the case, the termination is likely to prove fatal.

The *depressed form of manic-depressive insanity* usually comes on gradually. Patients begin by losing interest in their surroundings; they cannot apply themselves as usual to routine work; they find difficulty in keeping the run of conversation, or in keeping their thoughts on what they read, because the association of ideas is retarded. As the disease progresses, they show still more incapacity, indecision, inactivity. They have ups and downs, some days feeling like themselves, but gradually drifting into a sluggish, dejected, apathetic state, yet, as a rule, conscious of all that is going on around them. They sit with bowed heads and folded hands. When attempts are made to rouse them to activity, they seem powerless to exert enough decision to comply. "I can't, I'm so nervous," is the burden of their cry as they relapse into a listless, dejected condition. Constraint is a more prominent symptom than depression with these patients. They hesitate in walking and in speaking, sometimes merely moving the lips when questioned, as though trying to speak, but unable to do it. They look at everything through blue glasses, and if they voice their complaints, it is seen that they worry over the past and the future; they think that they are coming to want or to some dreadful torture. They are tired of life, and say so, but as a rule do not often actually attempt suicide. They usually recognize that they are mentally ill.

It is difficult for these patients to answer questions, to start to do the simplest act, or to think out the simplest thing. They are what we call retarded. They reply in a low voice, if at all, and usually in monosyllables.

Sometimes very depressing delusions arise: they think they are in the last stages of some disease, or that their stomachs are closed up; that they can never die; that their souls are lost; that the world is all gone; that their whole life has been one colossal mistake, and that they are bringing disease and ruin on all about them. Hallucinations are also common in this form, and are entirely depressive in character.

There may be a clouding of consciousness, partial with some, profound with others. Or there may be a torpor, a kind of dream-state, the result of extreme self-absorption, but from



which they can be momentarily aroused. Others sink into a stupor, in which they lie in bed, scarcely responding to any external stimuli, but showing on their countenances an expression of fear, and in their passive resistance and peculiar attitudes the presence of morbid anxiety.

The physical complaints are usually of numbness in the head, oppression of the chest, and palpitation of the heart. The pulse is slow; the blood pressure usually rises. The appetite is poor, and the digestive and excretory processes are sluggish. Sleep is broken and unrefreshing, and often disturbed by anxious dreams. The handwriting is faint and tremulous, cramped and shrinking in character.

The stuporous form shows a deepening of all the conditions till the patient experiences marked clouding of consciousness. Normal stimuli are not apprehended, and he becomes the victim of dream-like delusions. He feels himself in another world; all is changed; some terrible fate is impending. Hallucinations often persist after improvement has set in. The duration of the most critical symptoms is generally a few weeks; the entire depression usually lasts several months.

As in the manic phase, these cases tend to recovery, but also to a recurrence of attacks of one or the other form. Some, instead of showing any except the briefest period of sanity, pass directly from one attack into another. Improvement is usually gradual.

These patients enlist one's sympathy to an unusual degree since, during their lucid intervals, they are so rational, and so keenly alive to their condition, knowing as they do after several recurrences that fate has a sword of Damocles swung over their heads, and that, try as they will, they must needs succumb to recurring outbreaks.

Between attacks much can be done to ward off succeeding ones by so regulating the patient's life, occupation, and environment that excitement and strain are reduced to a minimum. Everything contributing to bodily and mental stress should be avoided as far as possible. Out-of-door life in the country is the one most to be desired. Especially is it important that plenty of sleep is regularly secured. Hurry, worry, ambitious undertakings, indulgence in stimulants, things that reduce the



bodily tone and harmony — all these are fruitful causes of recurrences. Wise supervision of the patient should be maintained by some competent person without the patient realizing that it is being done.

**Paranoia.** — Paranoia is one of the terms that has been a special bone of contention among students of psychiatry, some authorities compassing certain things in their use of the term, and others certain others of a diverse nature.

All that is attempted here is a description of what is most generally conceded to be meant by the use of the term.

The word, then, is usually applied to a mental disturbance which manifests itself mostly in early adult life ; which is usually progressive, and when typical is characterized by a well-defined system of persecutory delusions. As a rule it is seen in persons who are bright and clever, but have perhaps been narrow-minded and always considered a little "queer."

A study of the history of the patients who develop paranoia, or paranoid conditions, often reveals that some have been almost geniuses along certain lines. They show unusual association of ideas, see things in new and strange relations — an ability that in a genius enables him to profit by his vision, but in these persons too often comes to naught, from lack of power to make the new thoughts useful. Some of these persons are capable of inventions ; sometimes they can make suggestions that more efficient *doers* can carry out ; but as a rule most of their philosophizing consists in advancing impractical schemes for the furtherance of the welfare of a class or a race. From individuals of this class, according to their varying capabilities, we get inventors, busybodies, reformers, revolutionists, founders of new sects, cranks, and paranoiacs. Paranoia develops when the new ideas assume such one-sidedness and fixedness as to dominate the whole personality.

Persons with paranoia are the ones it is often so difficult for the laity to believe are insane, simply because consciousness remains unclouded, behavior correct as a rule, and the patients retain many of their mental faculties unimpaired. They often show remarkable ability in some one line ; their powers of reasoning are excellent, but in regard to their own false beliefs

reason is all astray because they start from a false premise. These patients usually consider themselves underrated geniuses. Extreme self-satisfaction is a striking feature in this form of insanity.

Early in this disease the patients become distrustful, and every trifling oversight on the part of friends is regarded as an intentional slight. Self-love is wounded at every turn, and the attitude of suspicion so characteristic of these patients begets continued unhappiness; trifles light as air become weighty proofs to them that they are objects of some special spite or scheme. Hallucinations, especially of hearing, may develop and confirm their suspicions. They may hear insulting voices calling them names, or accusing them of immoral conduct.

At first the wretched person quits his place of work under the belief that his associates taunt him, spy on all his acts, and are in league to drive him from their midst. A new field of labor is undertaken, and for a time all goes well; the suspicious attitude, however, is maintained, and it is not long before the same difficulties are experienced anew. He leaves and tries another place, and another, with the same result. He comes gradually to believe that all these persons have been conspiring to annoy and persecute him. He suffers intensely from the accusing voices that molest him. Chance items in the newspaper seem to bear some hidden reference to him; overheard comments of friends or strangers are wrongly interpreted as referring to him.

The feeling of self-importance that usually accompanies patients thus afflicted is in some instances carried to the extent of the patient's believing that he is the special object of Divine guidance, and that Providence has in view some secret mission for him to perform, hence the persecution to which he must submit. Another believes that he is a great personage incognito, that he was perhaps stolen in infancy from some royal household, and has been brought up in obscurity, and subjected to trials that will some day come to an end, and his vindication be triumphantly established. Whatever false beliefs develop, they are persistently held, and are finally woven into a plausible system. When these delusions are attacked, they are ably defended by the patient, whose reasoning is often startlingly clear and cogent, but, as before mentioned, on a false basis.

Some of these patients' delusions center about religious topics, others about sexual matters, political questions, etc., and their conversation and conduct are colored according to whatever subject engrosses the mind.

As a rule, patients may have this disease for years without showing impairment of memory or of the judgment (except in the field of their delusions), and many of them continue to take an interest in current events, literature, art, etc., showing their wonted discrimination and acumen.

It is to this class of the insane that "cranks" belong. As a rule, persons suffering from paranoia should be safeguarded in some institution, since the nature of their delusions is such, and their tenacity in holding them so great that, unless prevented, they feel bound to act in accordance with their false beliefs. Such acts often result in the destruction of the life or the property of whomsoever their delusions center about. Such persons so firmly believe that they are the victims of plots and schemes, that they easily justify themselves for avenging their wrongs, often even boasting that they are fulfilling God's commands.

Persons suffering from this form of insanity may have remissions of long or short duration, but it is one of the least hopeful of the psychoses.

**Epileptic Insanity.**—Epileptic insanity is a condition which sometimes accompanies the nervous disease, epilepsy, or "falling sickness," as it used to be called.

Epileptic seizures are mostly of two kinds, *grand mal* and *petit mal*, but there is a form called Jacksonian epilepsy; and there are outbreaks of violence, and dreamy states of longer duration than those of *petit mal* that are regarded as *epileptic equivalents*.

In *grand mal*, or greater epilepsy, there may be a warning—a something which the patient senses and which gives him a premonition of the attack. This is called the *aura*. It may be a numbness in some part, a tingling, a vague discomfort, or actual pain; it may be tremor, dizziness, nausea, or a gnawing feeling at the pit of the stomach, or a burning; or he may feel a sensation like a ball rising in the throat; may see flashes of light, colors, or animals before his eyes, or actual objects may appear

greatly magnified to him, or transitory blindness may be experienced. The disturbance may be in the sense of hearing — buzzing, roaring, ringing, and whistling may be heard; or he may smell disagreeable odors; or taste sweetish, bitter, or other tastes which have no objective reality. Or the aura may be psychic in its nature, and the patient be suddenly overcome with an indefinable fear, or may experience an indescribable sense of freedom and well-being. Still other auræ may show themselves in strange movements: the patient may start up and run rapidly a long distance, then fall in the convulsion. The aura, whatever its nature, is usually followed by a cry, then the person falls and becomes unconscious, as a rule, and convulsive movements in certain parts are later followed by general convulsive movements. The convulsive symptoms themselves barely last two minutes. The patient may become conscious almost immediately on their cessation, or unconsciousness may last for several hours.

There may be no aura and no cry; the fall may come without warning, and the convulsive movements are then usually observed first in a hand or a leg, but they may begin in almost any part of the body. The eyes roll up, the pupils dilate, the conjunctivæ show congestion, and the face gets swollen, blue, or livid; the reflexes are lost; the tonic and clonic convulsions are followed usually by stertorous breathing and by coma. The patient usually bites his tongue and froths at the mouth; there may be involuntary urination. The thumbs are more often than not placed between the index and second fingers. Sometimes in coming out of a convulsion, instead of sleeping, patients begin groping around on the floor as if in search of something. They are frequently observed to smack the lips during a seizure. Some show a tendency to fall in just the same way each time. In such cases the parts of the body liable to injury may be protected by pads worn for this purpose.

In *petit mal* there is a momentary loss of consciousness of a few seconds only, with or without slight convulsive movements.

In *Jacksonian epilepsy* the convulsive movements are confined to one part, *e.g.* an arm or a leg, or to one group of muscles. Consciousness is not lost as a rule, and the patient seldom falls.

In the dreamy states, or *psychic epilepsy*, there are no convulsive movements; there is merely a temporary blank in the consciousness, and when the patient comes to himself he has no memory of what transpired during the attack. This dreamy condition may last only a few seconds, or may extend over days and weeks.

The condition called *status epilepticus* is where attacks follow one another very rapidly, only a few minutes apart; they may be numbered by the hundreds; coma and exhaustion are continuous between the seizures; the pulse, temperature, and respiration are greatly increased, and the patient's condition is extremely critical.

A defective heredity is one of the most frequent causes of epilepsy. Alcohol is perhaps the next most frequent. A certain number of cases are directly traced to head injuries. Many cases of epilepsy develop in infancy or childhood, others come on in adolescence, and still others in advanced life.

Epileptics often present certain physical stigmata; their heads may be unnaturally large, or undersized. They often have what is called the epileptic physiognomy — a broad forehead, broad and flattened nose, protruding upper jaw, thick, coarse lips, staring eyes. Their teeth are often badly placed, their ears misshapen and outstanding. A case of long standing is likely to present numerous scars from cuts and burns, especially on the face and head, and if bromides have been given a great deal, there is likely to be seen the bromide acne. If much deterioration is present, the countenance is heavy and dull, or it may present a fatuous amiability.

In speech, the epileptic often shows marked disturbance. It may be abrupt, emphatic, impudent, jerky, or drawling.

When, as a result of epilepsy, a real mental disorder develops, we note impairment of intelligence and of memory to a greater or lesser degree, incapacity for effective mental work, marked emotional instability, lack of inhibitory power, and a weak and forceless moral sense. Persons so afflicted may be subject to periodical outbreaks of anger and violence, and to dreamy states in which there is partial clouding of consciousness. In



this state grave misdeeds may be perpetrated without a vestige of remembrance of them.

Periods of anger may precede or follow convulsions, or may occur independently. Sometimes days before the attack the patient is noticed to become talkative, fussy, and extremely fault-finding, harping on trifles that he would disregard any other time; his sleep may be disturbed also, and he may complain of headache, or may have all manner of trivial complaints for which he demands relief. He may make dangerous attacks upon others at these times, or may destroy clothing and property. Some patients are overtaken with a kind of furor that knows no bounds: some of them will run violently down the hall, and woe to any one or anything that gets in their way. They will strike or run down a living obstacle or demolish an inanimate object in a blind, unreasoning rage. Sometimes they will curse nurses and physicians in a blood-curdling way, yet these same patients, when not suffering from paroxysms, are often very kind and helpful, especially to fellow-patients, running to their aid when they, in turn, are taken with seizures, and showing considerable ability in dealing with the situation in a routine way.

Epileptics who are insane are weak in mind and morals. Their emotions are shallow. They can be trained to routine tasks, but their power of attention is of limited range and easily diverted. They are prone to read the Bible and to pray a good deal, and not infrequently are heard to speak familiarly of God as a sort of boon companion. One little epileptic, on being asked by the nurse if she was not going to say her prayers, said, "Oh, I forgot!" jumped out of bed, fell on her knees, hurriedly said, "Good night, God," and jumped back again. Another epileptic, who is much given to profanity before seizures, will at other times pore over her Bible, and ostentatiously inform every one that she is reading the Holy Scriptures.

Epileptics are tiresome in manner and conversation. They frequently request private interviews with a great show of something important to communicate, and with the intimation that secrecy is imperative, yet when given a hearing, it is usually found that they merely wish to tell you that they are getting

better every day, that they wish to go home; or sometimes they will give you a circumstantial account of some unimportant happening on the ward. Their memory and judgment are greatly impaired. They often make big plans and boast of what they are going to do, failing to appreciate their limitations; others, less deteriorated, are aware of their limitations, and chafe under their inability to undertake or to accomplish much outside of a very limited range. Where deterioration is conspicuous, behavior is often silly in the extreme; yet even these patients can be trained to become excellent helpers on the wards, and many of them are dependable, except when suffering from sulkingness or irritability, or from the actual attacks which overtake them from time to time. Illusions are sometimes noted after convulsions. Hallucinations and delusions are rare.

The prognosis in this form of insanity is unfavorable in the extreme.

**Hysterical Insanity.** — Hysterical insanity is a form of mental aberration characterized by very changeable emotions, weakened will power, and exaggerated self-consciousness, and with these there may appear from time to time certain attacks which present a variety of mental and physical symptoms, including dreamy states, numbness, and other abnormal sensations, paralyses, convulsions, blindness in one or both eyes, taste and smell defects, and the like. These symptoms are believed to be the outcome of morbid ideas and emotions.

Persons who develop hysteria are usually hampered by a defective heredity, as well as by their own morbid constitution. Defective training and lack of self-discipline, especially in the emotional field, are important factors.

Hysteria is by no means confined to the female sex; still it is more prevalent in girls and women than in men.

Patients with hysterical insanity show no disturbances in the field of consciousness except during their paroxysms or crises. They are keenly observant, often bright and vivacious, and may show exceptional talent in some field. They crave excitement, novelty, and the sensational. As a rule, the desire to attract attention and sympathy is so great that the patient will, perhaps half unconsciously, exaggerate and even invent symptoms.

They are fertile in arranging situations that will create a sensation. Some fabricate easily, if the truth cannot be made startling enough.

The most profound disturbance with these cases is in the emotional field. The patients are unduly excitable, their responses to everything are too keen, their sensations too easily aroused, and they give way to emotional outbreaks often on the slightest provocation. They are far too easily influenced by environment, and become unduly enthusiastic over any cause they espouse. Their enthusiasm leads them into all sorts of headlong acts; their obstinacy is extreme, and their regard for the point of view of others is entirely swallowed up in their own way of looking at a given thing and dealing with it.

Hysterics are very uncertain elements in the family life; self-absorbed and selfish, everything must bend to their feelings and their views. If the self-feeling takes a hypochondriacal turn, as it often does, the whole household is kept busy ministering to their slightest feeling of discomfort, which is dwelt upon and exaggerated till the patient grows to believe herself to be suffering cruelly.

If not enough attention is given to such patients to satisfy their self-love, they often make threats and sensational attempts at suicide for the purpose of impressing friends with the gravity of their condition. Because of the instability of the emotions, conduct becomes very wayward and erratic. In conversation everything is exaggerated with tiresome repetition. The superlative degree is called into use at every turn. These patients have little power of application as a rule, and are always talking of how tired and weak they are; yet they will spend hours in pottering about, and give infinite thought and time to trifles that ought to be disposed of summarily.

All hysterics are not alike, though certain traits are pretty common in all; the personality colors the general picture every time.

In the physical sphere symptoms may be very varied; there may be twitchings, contractures, paralysis of perhaps one arm or leg, loss of voice, numb areas, or areas of heightened sensibility, blindness, a ball rising in the throat (*globus hystericus*),

a piercing nail-like pain through the head, fainting fits, convulsions, and so on.

Persons afflicted with this disease may try to starve themselves, may refuse to walk or speak for years, may mutilate themselves, even torture themselves in order to produce strange or puzzling symptoms. Because of these morbid acts on their part, they arouse the scorn of on-lookers who fail to realize that such conduct and such feigning are in themselves proof positive of a deranged mentality.

The dreamy states that are experienced in some of these hysterical cases may be of short or long duration, and may or may not be accompanied by convulsions. It is sometimes difficult to distinguish them from epilepsy. Sometimes the patients appear to sleep quietly for long periods, and on awaking to have no recollection of the extended loss of consciousness. Sometimes the patient goes about in these dream-states, performing various acts with little or no recollection of them on returning to consciousness. In other cases, she appears to see visions, to hear beatific music, or to undergo most frightful experiences, or pleasurable ones — acting the while in the character of imagined experiences, regardless of all efforts of the bystanders to “bring her to her senses.” Some grow extremely fantastic or silly or sentimental in behavior, laugh and cry uproariously, scream, sing, shout, bite others, or themselves, bark like dogs, or mew like cats; and often these tantrums end in a short convulsive seizure, after which the patient comes to herself and appears mildly depressed, but unaware of what took place in the hysteric episode.

There are cases where the patient seems possessed of two or more personalities, so that in one state she seems conscious of certain experiences, and lives up to a certain character, while in another state she seems an entirely different being, with little or no recollection of the feelings, thoughts, and experiences that came to her in the first-named consciousness.

The mind seems to split up into two or more consciousnesses, because the person is too nervously weak to hold it together. Certain patches, as it were, of the consciousness seem to become submerged at times, and so become a part of the subconscious

existence. During grave hysterical episodes these subconscious patches may become uppermost, while the usual upper consciousness is temporarily submerged.

Patients with hysteria may be afflicted for years. Remarkable cures have been effected through hypnotism by getting at the subconscious undercurrents that have been at work, perhaps for years; and also by bringing about sound physical health and mental hygiene.

**Acquired Neurasthenia.** — Acquired neurasthenia, or nervous prostration, the so-called “Americanitis,” is one of the functional nervous disorders that demands brief consideration. It is not, so far as known, dependent upon actual cell changes, but its presence is known by its morbid manifestations. It is a disease which attacks the over-employed, the brain worker particularly, who is subjected to prolonged mental application combined with worry and responsibility.

Its manifestations are not very different from the congenital form of neurasthenia described below.

Persons suffering from nervous exhaustion are popularly spoken of as “nervous.” What is it to be nervous? Used in this sense, it means to have exaggerated sensibility, exaggerated fatigability, and exaggerated emotionalism. “Nervous” persons can’t meet the ordinary ills of life with a normal degree of fortitude; they grow discouraged with the smallest failures, magnify every obstacle and profess inability to surmount it; create painful emotions by representing to their minds ideas of danger, of evil, of fear. Instead of opening a telegram and finding out its contents, they fear and tremble and conjure up all the terrible things it might be, and put the worst possible construction upon everything. They seem incapable of looking at a question calmly; we say of them that they make mountains out of molehills, then toilingly climb these self-created mountains, when a wholesome faith and a sturdy common sense would remove mountains; or, perhaps it is better to say, a clear-eyed reason would discover that the mountain needs no removal, being only a molehill.

**Constitutional Psychopathic States.** — There are certain conditions called constitutional psychopathic states that demand a



few words before leaving the subject of the forms of mental disease. Congenital neurasthenia and compulsive and impulsive insanity are the ones we shall briefly consider.

**Congenital Neurasthenia.** — Congenital neurasthenia is a condition of nervous prostration ingrained in the person. Such are literally “born tired,” are easily depressed, and prone to indecision, yet show no disturbance in the field of consciousness nor in the intellectual field, so that it seems strange to a casual observer to class them with the insane. Continued application in these persons causes an undue sense of fatigue, headache, and sleepiness. They become hypochondriacal and self-centered. They are easily turned aside from their work. The power of attention is very poor. Such persons are easily balked in any undertaking. They are the prey to morbid fears. If they have a sore throat, it is going to be diphtheria; if the nosebleed, they fear a fatal hemorrhage. They cross innumerable bridges that they never come to, and die a thousand deaths while conjuring up others to die of. Slight troubles and indispositions affect them seriously, and grave ones often cause profound depression. In action they are usually precise and constrained. The disease may extend over a whole lifetime, with periods of comparative comfort between.

**Compulsive Insanity.** — Compulsive insanity is a morbid condition in which the intellect continues undisturbed, but the patient is dominated by compulsive ideas and fears which force themselves upon him against his will, seriously interfering with thought and action. These may be indifferent ideas or intensely disagreeable ones. This condition is only an exaggeration of what we all experience from time to time in perhaps trying to recall a forgotten name; although we keep saying to ourselves that we will dismiss it from the mind, the effort to recall it keeps cropping up in spite of ourselves.

Sometimes the compulsive ideas are very absurd, and the patient recognizes them as such, nevertheless is dominated by them.

The various fears or *phobias* come under this head — fear of dirt, of contamination, of phthisis, or of other diseases, of open places, of the dark, of crowds, and the like. Patients suffering

from these compulsive ideas will wash themselves by the hour, if fear of contamination is the particular obsession; they will face death almost as soon as go to a church or to the theater, if it is the fear of crowds that dominates them. Others are afraid of committing some crime, and take all sorts of absurd precautions to assure themselves that they have not committed it.

These patients can comment intelligently about their fears, and realize their absurdity, but are powerless to rise above them. They may be capable of concealing the fear before strangers for a short time, but if one takes away their means of reassuring themselves (for example, locks them out of the bathroom and prevents the frequent washing, if *mysophobia* happens to be the morbid fear), these patients will develop a restless, agitated condition distressing to witness.

Some *psychasthenics*, as some of these persons are called, are forever asking and trying to answer questions to themselves, some of which are absurd, some metaphysical. It is with them as though the "why" of childhood were carried on to adolescence and maturity. Some persons always remain adolescent of soul. Certain ones of this type will query, "Why is the grass green?" "Why does c-a-t spell cat?" Some will debate with themselves as to whether, if they had pursued a certain course, the result would have been this way or that way; some dwell long on why God made the world, what is the purpose of evil, and so on; the broader the education, the more inclined are these persons to *mental rumination* on metaphysical questions. They chew the cud of these thoughts over and over as a cow chews her cud. They are prone to silly scruples and perhaps to abnormal states of exaltation and mystic delirium. Some waste a good deal of time putting things to rights, working out problems, repeating numbers, counting how many times they do a certain thing, etc., all of which are signs of mental fatigue. Some are very hypochondriacal, and are always diagnosing their troubles; some are excessively shy.

These persons often show facial *tics*, exaggerated reflexes, skin-writing, very changeable pupils, anemia, and palpitation.

**Impulsive Insanity.**—Impulsive insanity is similar in some respects to compulsive insanity. It is characterized by the

development of irresistible *morbid impulses* which suddenly crop out and govern the actions in an entirely unpremeditated way, usually much against the patient's will. It may be the impulse to set fire to a building, to steal, to destroy property, to assault or to kill, to commit some unnatural sexual act, in persons who are not criminally inclined, and who, as a rule, abhor such conduct. These morbid acts are likely to be followed by a feeling of relief.

**Defective Mental Development.** — When in early life the brain cortex fails to develop normally, varying degrees of defective mentality are observed; the lighter ones are cases of *imbecility*; the graver ones, cases of *idiocy*.

An *idiot* is a person devoid of understanding from birth. He perceives nothing intelligently. There are *absolute idiots*, *fools*, or middle-grade idiots, and a higher grade that are sometimes called *simpletons*.

The *imbecile* is a feeble-minded person, his condition being due to arrest of development at an early age. There are *low*, *middle*, and *high-grade imbeciles*, according to the degree of intelligence and to the development of the moral nature; but all imbeciles, of whatever grade, are unstable, inefficient, and irresponsible. Imbeciles of high grade are often spoken of as "backward" or "simple-minded."

*Idiocy*, as well as imbecility, has defective heredity as the most frequent background for its development. Some idiots have abnormally large heads, while others have abnormally small ones. Faults of development, lack of symmetry, and other abnormalities are noted in the brain. Physical *stigmata* are numerous — receding foreheads, deformed ears, badly placed teeth, defective hearing, incoördination of the muscles, stunted growth, and many other defects make these children pitiable objects to behold. Some idiots are so defective that their attention cannot be fixed even momentarily, while others are capable of a little direction in the attention. Idiots are incapable of intelligent expression in speech or action. They cannot care for themselves or make known their wants. They are the prey of their ungovernable impulses and their animal-like propensities.

The *imbecile* is able to care for his person and to attend to

his physical needs ; he often speaks intelligently, is not especially hampered in his muscular movements, and is capable of some facial expression. He shows a lessening of the normal mental and moral capacity. The power of attention is poor, and the ability to relate impressions and experiences to one another is slight, so that, although the person may see this and that clearly, he is usually unable to grasp the ideas resulting from his experiences, and so form conclusions. Such defective persons are very egotistical, overbearing, and selfish ; they are often cruel, too, because they are incapable of taking in the whole of any situation, and are only sensitive to what concerns themselves. As these defective children grow older, their incapacities become more and more apparent. Some imbeciles are sluggish and some are of the active type. The emotions are very unstable, and are often extravagantly expressed.

Certain physical stigmata are seen in imbecility as well as in idiocy. Imbeciles as a rule are very susceptible to alcohol, and some of their most dangerous outbreaks are provoked by a slight indulgence in it.

In spite of all the limitations of these defectives, institutions and teachers for these unfortunates have proven that some imbeciles can be trained to lives of self-controlled usefulness, even though in a narrow range, and that even the worst idiot, if taken early enough, can be trained to be less repulsive and less wretched than he would otherwise be if patient and intelligent efforts were not directed in his behalf.

## CHAPTER XXVII

### NURSING IN THE VARIOUS FORMS OF MENTAL DISEASE

THE probationer who undertakes the care of patients with mental disorders has much to unlearn as well as to learn. Even in this enlightened age the opinion still seems rather prevalent that mental invalids are to be humored in their fantastic beliefs, deceived and entrapped into conforming to necessary measures for their care and safety, and ordered about and coerced into obedience if inclined to rebel or resist.

If, as probationers entering a hospital for the insane, you have believed that harshness and unkindness to patients are necessary means for subduing them, or are knowingly permitted, you will soon learn how erroneous is that belief.

If you have thought that to be insane a patient must present the appearance usually ascribed to them — staring eyes, disheveled hair, disordered dress, and a raving manner — you have found yourself forced to abandon that view, and have gradually learned that the manifestations of insanity are about as many and as varied as are the classes and conditions of men. You have soon learned that some of the patients whose mentality is most grievously warped and distorted are capable of as quiet and restrained demeanor as the majority of persons outside a hospital, and that to be insane does not mean that all the mental faculties are conspicuously disturbed, altered, or impaired.

Many of our patients, and some who are in reality hopelessly deranged, present nothing in appearance, dress, manner, or conversation that to an untrained observer would reveal their departure from mental health. Many others can maintain a proper behavior and rational conversation for given periods, and then are forced to give way to unmistakable manifestations of their disease. Certain cases appear to a casual observer only



a little dull and dejected, others as merely stubborn, or boastful, or a little excited and loquacious, but "surely not insane," while still others are regarded as much-wronged "and perfectly sane" individuals who are unjustly detained in hospitals by the authorities. Let me say, in connection with this erroneous notion, that our State hospitals are in such a crowded condition that we welcome every opportunity for discharging patients when it is wise or safe to do so. Some of the very patients who chafe most under hospital restraint, who appear to a casual observer to be unjustly detained, are persons we would be only too glad to be rid of did we not feel that dismissal would be followed by most unfortunate consequences, sometimes even by disastrous ones.

If you have come here with the preconceived idea that patients are placed here merely for custodial care, in order to prevent them from doing harm to themselves or others, or from injuring property, and that their care is accomplished simply by keeping them behind bars and within closed doors, coercing them to conformity to the rules of the institution and prohibiting them from dangerous conduct, you will soon learn to alter that opinion. You will find that our State hospitals of to-day regard custodial care, though necessary, as the least important of their functions, and that the policy of the heads of these hospitals is to lessen restrictions, to remove restraints, and to permit just as much liberty as is possible with safety to each patient within their walls. You will find that entire wards, and in some cases entire buildings, are conducted on the open-door system, large numbers of patients going and coming at will during the day, and proving themselves entirely worthy of the trust reposed in them, at the same time that they are unquestionably insane, and in need of the care that the institutions afford.

You will find that the aim of these hospitals is, in addition to permitting as much liberty as is compatible with safety, so to minister to the patients as to upbuild their sick bodies and restore their disordered minds; and you will see that many a patient enters the wards in a reduced state of body and a disturbed state of mind, and, after receiving proper bodily care, and attention to the mental and moral needs as well, leaves the institution restored and in his right mind.

If you have held the opinion that the false beliefs of the insane are to be humored and indulged, you will soon learn that such is not the case; on the other hand, you will also learn that it does little good to contend or to argue concerning delusions, and that a quiet diversion to some other topic is wiser than to attempt to convince a patient of his erroneous beliefs.

If you have thought that the easiest way is the best way, and have considered it justifiable to resort to duplicity and deception in your dealings with these patients, you must abandon this false notion at the outset, as such methods are most reprehensible, they defeat their own object, and are not to be tolerated by any enlightened, high-minded person.

The best results will usually be obtained by treating the patient as though he were a reasonable being, when this is at all practicable, and by letting him see at every turn that you want to help him in his difficulties, whatever they may be. They probably seem absurd to you. They are real to him. You also need to show him that in order to have order prevail and justice done to all, certain rules have to be obeyed, and that as members of one big family we are all here to help one another. By maintaining this attitude you call out the best in your patient and in yourself, and so provide a good groundwork of mutual understanding, which is necessary if you are to be a real help to your patient.

It is not necessary for the nurse to know the name of the mental disorder from which the patient is suffering in order to nurse the patient properly. The important thing is to deal with the conditions. If there is excitement, seek to allay it; if fear, to remove it; if anger, to dispel it; and so on.

In dealing with the insane we need to keep in mind that we are dealing with persons whose personalities have undergone a change, who are often unreasonable, and not amenable to ordinary methods of treatment. On the other hand, we need to remember that many of them can be appealed to in a perfectly reasonable way. While most of our patients are susceptible to real kindness, some are malicious and unapproachable, and will willfully misrepresent and misinterpret all that is done and said, and will sometimes go out of their way to be annoying to

the ones who are trying to help them. We will look more charitably upon their ill-humored and malicious deeds, upon their abusive and disgusting talk, if we keep in mind that they are seeing as through a glass darkly, and that things are distorted, as well as seen in an unnatural light, and that it is for us to lead them to see more clearly if we can; but if that is impossible, we are here to bear with their warped personalities, and to prevent their false beliefs from working injury to themselves or others.

We can best help our patients by teaching them self-control, and we can best teach self-control by making things as easy for them as possible, and not put their irritable nervous systems and unstable emotions to too strong a test.

Kindly, patient suggestion, and respect for the patient's point of view, even when it is erroneous, and a persistent endeavor to help him to seek the best course in any situation that confronts him — these are true reformatory measures.

Even with so-called *incorrigible patients*, much can be done to win them to better ways of acting. Patterson Du Bois, in speaking of the relation of parents to children, gives us a hint as to how to deal with our "incorrigibles." He says that the true father says not, "I will conquer that child, whatever it costs *him*," but, "I will help that child to conquer himself, whatever it costs *me*."

A nurse who lacks calmness and persuasive power cannot cope successfully with obstreperous patients. Neither can one who is not willing to take infinite pains; for it requires continual study, planning, and arranging of ways and means for drawing off the energy from mischievousness and vice to industry. Dr. Maudsley enjoins that we counteract commotions within the patient by an absence of commotion in his surroundings.

Appreciation will do more to work a reform in your patients than criticism and condemnation. Reprimands emphasize faults, while commendation makes patients wish to do better in order to gain approval. One can often appeal to a patient's desire to please, or to his curiosity. Get him interested in things, keep his hands busy, show him how to do simple things well, stimulate him by approbation. First say, "Come, let me show

you how"; later, "Now *you* do it"; still later, "See if you can show *her* how" (referring to another patient). Take an interest yourself, and your patients will. Appeal to their powers of imitation, emulation, ambition, pride, ownership, and above all to their constructiveness. Never appeal to their pugnacity. Make your patients love you, not by familiarity, nor by coddling, nor by favoritism, but by letting them see that you have a genuine and deep-seated interest in their welfare.

**Care of the Chronic Insane.** — Perhaps it is well first to offer some suggestions as to the care of the chronic insane, since this class constitutes so large a proportion of our hospital population. It must be remembered that those we call the chronic insane are made up from the various disease-groups already described, and are by no means all to be handled alike.

We may say in a general way that the care of the chronic insane consists in hygienic housing, and in training to good habits and to some useful work. Attention to ventilation, bathing, food, elimination, exercise, and sleep is included in hygienic care. Physical ailments need to be promptly recognized and relieved, if possible, and the patients' lives so regulated as to supply diversion as well as occupation.

A great deal can be done to quell disorder and discontent by personal attention to the tastes and propensities of each patient. What works well with one will by no means always answer with another. The nurse who has the neatest, quietest, most orderly ward is the one who studies her patients and helps them to adapt themselves to one another and to their surroundings. Patients get into good ruts as well as bad ones. This is a very comforting truth. It is owing to this truth that untidy and unclean patients can be trained to be cleanly, that bad postures and habits can be corrected, that good table manners can be developed, that idleness and apathy can be made to give place to industry and interest; that the habit of self-mutilation can be broken up, and that even long-standing cases of deterioration can, by patience and persistence, combined with resourcefulness on the part of the nurse, be trained to orderly routine in some useful work.

We need to remember *in deteriorating cases*, for example, in

*dementia præcox*, to save all that there is to save of the mentality by keeping patients occupied and interested. It is surprising what interest can be aroused if one will but watch for whatever calls forth the slightest show of interest, and, taking that as a hint, fan the spark to a steady flame. It may be a love of dogs or cats, it may be liking to see things grow, it may be the doing of some work which the patient learned to do before his mind became so disordered — whatever it is, select the thing in which you find the patient will take an interest, and furnish him occupation along these lines. A pet dog belonging to an attendant, if given over to the care of a chronic patient, may furnish a real interest to that patient that will make her days anything but the colorless times they would be without it. She grows to consider the needs of the dog and to conquer her own ill-humored spells of sulking indoors. A family of kittens reared on the ward can furnish diversion for many, and really be the means of arousing apathetic ones. A window box of growing ferns, a single plant given the patient to care for, a sprouting sweet potato in a glass, a sponge filled with canary seed, growing bulbs, branches of an apple tree or of a lilac bush forced to bloom in the house in early spring, a canary bird to care for, even a pet mouse — these simple means are often a great help in awakening the attention of patients in things outside of self, and later of leading them to doing things.

In all forms of insanity where the judgment is much impaired the nurse needs to watch over the patients and protect them as one would a child. Many such patients are too demented to complain when they suffer from physical ailments. You will need to watch such patients to see if they eat poorly, if they cough, and perhaps expectorate slyly in out-of-the-way places, to see if they have a fever, or need attention to the bowels.

In trying to teach *inattentive patients* to attend to things in order to learn to do even the simplest tasks, you need to know that there are easy stages by which this may be brought about. First, arrest the patient's attention. This may be done in various ways, by variety, or novelty, or by some sudden or unusual way of calling his attention to it; then by repeatedly arousing his interest in it you will find that he gradually learns to have a



livelier appreciation of it. Then is the time to get him *to act* concerning it; to take hold and do it himself; and from this stage he gains a real personal interest in the thing, so that he has a love for it, or a desire to excel in it, as the case may be; and when this point is reached, the thing comes to be part of his experience and to have a real relation to the rest of his life.

*Patients* who are inclined to be *careless and slovenly in dress* can never be won over to neatness by indifference on the part of the nurse. There is too much of a tendency to think that anything is good enough for such persons, and misfit clothing, mismated hose, boots laced up with a corset string, or "any old thing" is put on the patient. Try what you can do to stimulate pride by an entirely different course; take special pains to put on a bright-colored gown or a new pair of shoes, to arrange the hair becomingly, and see what this course will do.

*Patients* who are *destructive* of clothing must be furnished with material not easily destroyed, but in addition to that should be furnished with a legitimate outlet for pent-up energies, if the habit of destructiveness is to be broken up.

*When patients are restless*, learn whether it is from lack of occupation and boredom, from physical discomfort, or mental unrest, or anxiety. When the cause is ascertained, seek to remove or to alleviate it as far as possible.

*When patients are violent*, it is either from anger, from maniacal excitement, from epilepsy, from impulsive outbreaks, from pain and discomfort, or as a result of false perceptions or beliefs. Here, too, the cause of the violence should be sought and alleviated. In many persons subject to violent outbreaks you will observe that certain symptoms are pretty likely to precede the violence. This will put you on guard. In certain ones the outbreak is preceded by stereotyped complaints, in others by extreme pallor, or a peculiar tremor of voice, or by profanity. Impulsive cases usually give no warning. Such patients should be carefully watched that they do not have access to things they could use as weapons.

When it is necessary to approach a patient known to be violent or homicidal, always have plenty of help at hand, if possible. Let one attendant grasp one arm, one the other, at

the wrist and elbow, holding them out straight, and using no more force than necessary. A third attendant may stand behind and hold the chin if necessary, to prevent biting and spitting. Walk the patient backward and seat him in a chair. Do not hold him after violence subsides. Let him scold if he is so inclined; it is better that the excitement finds an outlet in noise than in violence. Hot packs, if prescribed by the physician, also isolation, are soothing measures in these cases, if properly applied.

There may be rare occasions where it will be necessary to approach a violent patient with a blanket, throwing it quickly over the head long enough to enable you to get control of him, perhaps to get a weapon away from him. But such cases should be reported to the office at once. Seclusion is often profitable in these cases, but permission should always be first obtained, except in grave emergencies.

Sometimes when a violent patient, perhaps with a weapon, is in a room, and it is necessary to enter the room before his rage subsides, the foremost attendant may approach by carrying a mattress lengthwise in front of him, as a shield, and the others rally their forces as opportunity offers. Violent men patients about to strike may be prohibited if one can seize the coat from behind and quickly pull it down upon the arms; spitting and biting patients may, if necessary, be checked by holding a towel in front of the face, but never over the mouth. In struggling with violent patients, whatever the provocation, never apply pressure to the throat, chest, or abdomen.

The tactful nurse, whose supervision and management are what they should be, will seldom let things reach a physical contest. A physical struggle with a patient is degrading to both nurse and patient. It lessens the patient's self-respect and leaves him with a feeling of degradation, and the memory of the struggle engenders bitterness between nurse and patient that is difficult to overcome.

Certain patients will at times be untidy and boisterous in spite of all one can do to counteract these tendencies. Such should be kept in rooms in the rear of the building; when taken out on the grounds, they should be kept in the least frequented parts.

There are times when to go on certain wards is to say with

Uncle Toby in "Tristram Shandy," "Our armies swore terribly in Flanders, but nothing to this;" but deplorable as are some of these manifestations, there is no question but that the noise and violence, and much of the profanity and obscenity, can be greatly lessened by furnishing these same patients with occupation and exercise, and by reducing causes of irritation to a minimum by constant judicious oversight.

In all cases of *exhaustion*, from whatever cause, the main things are to build up the body, promote sleep, conserve the strength, and see that the bowels, kidneys, and skin are doing their work.

Light liquid diet at regular intervals should be given as ordered. Exhausted cases should especially be fed in the early morning hours, when the vital powers are at their lowest ebb. Saline hypodermatic injections, and saline enemata, may be called for. Light and noise should be reduced to a minimum. The patient should be kept in bed, warm baths and other hydriatric measures may be employed to reduce restlessness and delirium. The patient should not be argued with if exhausted, and if delirious should not be left alone an instant day or night. Exhausted and delirious cases should not be considered well until they have regained their former weight.

The *nursing of delirious and stuporous cases* is practically the same, and applies also to exhaustion and infection cases, to stupor from dementia, from shock, hemorrhage, head injuries, typhoid, and the like.

Cases of stupor, whatever the origin, need bodily rest, extra nourishment, extra attention to the functions of defecation and urination; they need frequent administration of water, frequent baths, and building-up treatment generally. They should not be expected to lift their fingers, even; every atom of strength should be conserved; everything should be done for them kindly, quietly, and with apparent leisure. All noise, bustle, and confusion must be avoided, for though apparently unconscious, the injurious effects on the nerves of these disturbing agencies are just as pronounced as though the patient perceived them.

If the temperature is subnormal, as is often the case, attention to sufficient clothing and coverings and to artificial heat is needed.

The sensibility being reduced, great care is required to prevent burning from applied heat. The weak heart's action, seen in the slow, small pulse, and cold, blue extremities, shows how important it is to conserve and add to the strength at every turn.

If the skin is dry, inunctions are indicated. The tendency to bed sores has to be constantly guarded against. The involuntary evacuations of urine and feces require the utmost attention and cleanliness, and the tendency to retention of urine and over-distension of the bladder is equally important. The drooling of saliva, the accumulations of secretions in the corners of the eyes and in the nostrils, call for fastidious care on the part of the nurse. The rapidly forming *sordes* on teeth and tongue demand assiduous care.

Patients that are delirious or in a stupor require painstaking administration of food, as well as in regular and sufficient quantities. Sometimes, when urging them to swallow food is of no avail, rubbing the lips with the spoon will cause them to open the mouth and swallow, even though they are unconscious. This will also often work in the giving of medicine.

The utmost care is needed if artificial feeding is resorted to, and this should never be undertaken except in the presence of the physician.

The *treatment of the Intoxication psychoses* varies according to the various forms. The withdrawal of alcohol is one of the first things to do. Treatment is then directed toward promoting sleep, and nourishing the patient, watching the excretory functions, and in preventing injury to self and others. The moral treatment consists in encouraging the patient in the belief that he can conquer the habit when he is properly fortified by the treatment; and also in making him see clearly how odious it is that he has been a slave to the habit for so long, and how desirable it is that he abandon it now for all time.

In the delirious forms, remember that it is very injurious to use mechanical restraint. Seek to allay delirium by warm baths and to keep the patient in bed by putting him back as often as he attempts to rise, but do not restrain him in a safety sheet

or a pack. Patients with *delirium tremens* are likely to attempt to leap out of the window.

The *treatment of Morphinism and of Cocainism* are very similar. Complete abstinence can usually only be secured by placing the patient in an institution. The relatives must refrain from dictation, leaving the control of the case to the physician. The patient should be put to bed. Rapid or gradual withdrawal of the drug is decided upon by the physician. Watch for abstinence symptoms and for signs of collapse. Heart stimulants may be called for in some cases. Abdominal packs, salt baths, and other baths, intestinal douches, the copious drinking of water, and massage are of great help to promote sleep. If both morphine and cocaine have been used in a given case, cocaine should be withdrawn first. The diet should be light. Small quantities of food should be given at frequent, regular intervals. Tea and coffee are helpful in allaying restlessness.

It is well to put the patient in a darkened room and let him sleep in the middle of the day at the beginning. Later he will begin to feel sleepy at night, and more and more sleep will be secured.

Pains must be taken at every turn to establish confidence in the curative measure used by the physician, and to maintain this confidence. Morphine habitués are vacillating and are all the time wanting a change of treatment. The patient, even if a physician, must be made to understand from the start that he must give himself over entirely to the direction of the physician, if he is to be cured.

The treatment as a rule should extend over six to ten months, in order to cover the periods of restlessness and irritability that are likely to recur every few weeks, at which times, if unguarded, patients are especially liable to relapses. It is difficult to persuade a patient to submit to the treatment after the sense of well-being and the marked improvement appear (usually between the second and third months of treatment), but unless he can be so persuaded the early treatment is of little avail.

Surveillance must be maintained long after active treatment has ceased, and the after-care must consist in removing all nervous strains and all temptations as far as it is possible to remove



them. A radical change in one's life is desirable on leaving the institution. Brain workers should become muscle workers and lead wholesome out-of-door lives.

In the *treatment of Dementia Præcox*, rest in bed and nursing directed to improving the nutrition are important in the beginning. Forced feeding may be necessary; cold baths, friction, and spinal douches help to improve the sluggish circulation and the shallow, irregular breathing; abdominal packs are also of use. Especially important is it to train to habits of cleanliness. The resistance so common in these cases can sometimes be circumvented by asking the patient to do just the opposite to what you wish him to do.

As these patients improve physically and are able to be about, efforts should be directed toward educating the undisciplined nature as far as possible, by teaching self-control and by requiring the patients to *do* instead of *dream*. Each day they should be patiently trained to accomplish certain tasks, care being taken not to select things too hard for them.

Deteriorated cases should be especially protected in cold weather, as they are too dull to tell when they are insufficiently clad. They should also be guarded against burns and scalds, not allowed to lean against hot pipes, or to turn hot water on themselves. Distention of the bladder must be guarded against.

The *treatment in cases of General Paresis of the Insane* is to safeguard the patient and his friends from his numerous impracticable schemes, or from his violent outbreaks, and to regulate his diet, sleep, and exercise in accordance with his needs and strength. Uncleanliness must be forestalled by watchfulness, also accidents arising from the patient's stupidity, clumsiness, and uncertainty of movement; prevention of bed sores is needful, and it is especially important that paretics be closely watched when eating, to prevent choking. In all cases of paresis, it is better to feed the patient than to let him feed himself. One must watch that the paretic does not retain urine and feces. Saline infusions and saline enemata are very useful in paresis.

In the *treatment of Melancholia* one of the first things is to remove the patient from familiar surroundings and from his

friends, as these only serve to aggravate his condition. It is a great mistake to attempt to divert the patient, to take him on a journey, or to insist upon his seeing company. These well-meant efforts to cheer him up are not only useless but even harmful. The patient should be put in bed and kept there the greater part of the time, and required to take small quantities of easily digested food at frequent intervals. Patients will often refuse food from a feeling of unworthiness or from fearing that they are robbing some one else. It is not well, especially in the former cases, to appear to notice the patient's objections, nor to urge him to eat, but leave food near, and give him a chance to eat unnoticed. The free action of the bowels is especially important. Warm baths are a decided help in favoring sleep and in mitigating the restlessness that overtakes the patient from time to time. Sometimes compresses over the heart are helpful in allaying the agitation so common in this disorder.

Visits from friends should be absolutely prohibited until a decided improvement is observed.

These patients should be under continual observation day and night. As they get stronger they should be drawn out in conversation to prevent brooding, and later should be furnished with light, interesting occupation. The *danger of suicide* must never be lost sight of, even after marked improvement is noted. Especially should patients be safeguarded in this particular at night and early mornings, when their despondency is often most profound. It is a good plan to give suicidal patients a cup of hot milk on their awaking, as this serves to lessen the morning depression.

It is surprising what schemes suicidal patients will evolve to obtain means for self-destruction. They will crawl through transoms and wickets, make keys and unlock doors, try to drown themselves in the bath tub, to hang themselves with a sheet, or with their nightgown made into a rope, or with the cord from a bath robe, or a necktie or apron string; they will eat soap, drink ink, paint, or disinfectants, and break windows or tumblers to secure sharp pieces of glass with which to cut their throats or wrists. They are often very shrewd, and select times when something unusual is going on and the nurses are somewhat off their guard;

for example, the nights of the dances, when visitors are on the wards, or when other patients are demanding extra attention. Suicidal patients should never be allowed to lie with their heads covered, as they may strangle themselves in bed with the nurse sitting close by. They should be undressed each night, and clothing and bed carefully searched to make sure that they have secreted no weapons during the day.

When out walking near bodies of water, going downstairs, or when near clothes chutes, suicidal patients must be carefully guarded lest they make a sudden spring and drown themselves, or dash themselves down from a height, or throw themselves in front of horses, or trolley cars, or automobiles, or lest they pick up glass or tin with which to cut an artery. Some suicidal persons will save their medicines slyly with a view to accumulating enough to form a fatal dose; some will feign cheerfulness and talk hopefully of what they intend to do when they get home, just to get the nurse off guard so that they can accomplish their own destruction.

Much can be done with depressed cases in assuring and reassuring them, day in and day out, that they will get well, that their suffering, hard as it is, will have an end — the turn in the lane will come at last. Lead them out of themselves by mild diversions without appearing to take too much notice when they begin to respond to your efforts.

*Patients suffering from Senile insanity* cannot be taught very much, because memory is so impaired; neither can they be reasoned with very successfully. Our efforts at helping them must consist of repetition and patience when necessary to train them to certain things, and in time we may get an automatic obedience. We must deal with them much as we would with a very young child, reward them when they do the right things, express regret and disapproval when they do the wrong ones, but do not let expressions of disapproval take the form of unkindness or harshness. These patients need to be carefully watched to prevent self-injury, not from intention so much as from loss of judgment and insight. They think themselves capable of doing just as they used to do, and in this way often come to grief. If very feeble, they should be kept in bed. They need to be safeguarded

against falls on polished floors and on wet and icy places. Their bones are very fragile, and slight falls result in fractures and dislocations; sometimes the force exerted in dealing with them, when they are resisting, results in fractures.

Senile patients are very trying because they are so fussy and meddlesome and so incapable of being made to understand things. Because of this they must be protected from irascible and violent patients who will attack them when angered by their meddlesome ways. Senile cases worry over trifles; they suffer if they drop a pin and can't find it; they are in a hurry about everything, in a hurry to get to places, and in a hurry to get back. They live in the present moment, but weave the events of the past in their talk as though these were taking place also. They often suffer from persecutory beliefs, and need to be soothed as one would a tired, fretful child.

The *nursing of Manic-depressive insanity* should consist largely in keeping the patient well nourished, and in securing the greatest possible mental quietude.

Although the excited and depressed types are so varied in their manifestations, certain measures apply to the one form equally as well as to the other. Careful observations of the weight, at least twice a month, should be made and recorded. So long as the weight falls in either form, a favorable prognosis cannot be given, even though the mental state should show improvement. Attention to easily digested food given at regular and frequent intervals is all-important in both forms of the disease. Rest in bed is likewise equally important in both; for the excited cases because they expend so much strength in extreme psychomotor activity, and for the depressed forms because nutrition and strength are at the outset usually below par.

Isolation also is desirable in the treatment of these opposite conditions. Excited patients, with their exaggerated impressionability, their ready reactions to all sense impressions, need to have all external stimuli reduced to a minimum, since everything that the patient sees, hears, and experiences serves as an added excitant. The need, then, is to lessen brain activity as much as possible. If such patients cannot be cared for in a room by themselves, a certain amount of isolation can be secured

by screening the bed and by keeping the infirmary as quiet as possible. They should not be urged to exert themselves nor to take an interest in things in the acute stages, but time, rest, and feeding should be given a chance to do their work.

Constant supervision of excited patients is needed to prevent them from carrying out mischievous, belligerent, or destructive impulses. Infinite tact is required in dealing with them. We have seen how their self-valuation is heightened. This shows itself in their boastfulness, their monopolizing of the attention, and their absurd attempts at personal adornment. Where self-feeling is so strong it is likely to be equally sensitive to slights or criticism. Where self-love is hurt by inattention or reproof, or humorous or sarcastic remarks concerning their appearance or conduct, they are much given to abusive and violent outbursts.

Avoid laughing at your patient's witty sallies or encouraging his fantastic dress or grotesque behavior. These may be very amusing, and it may be a temptation to draw the patient out; but remember that psychic rest is what he needs, that soothing instead of stimulating influences should be provided. At the same time these manifestations should be met with the nicest tact. It is best to humor manic patients within reason, to avoid seeming to oppose, to restrain, or to contradict them, nevertheless you are to maintain a watchful eye over them. By timely suggestions and diversions and tactful means you can, all unknown to them, safeguard them from their impulses and prejudicial tendencies.

Study each patient, learn what things excite him, and how he is likely to react to them, and forestall these reactions by removing the causes, or by removing him from the causes, in such a way that he does not suspect that he is being managed. This can be done without resorting to insincerity or untruth. Make him no false promises. Let him feel that he can always rely upon what you tell him.

Erotic patients must be prevented from making shocking exhibitions of themselves. Their tendency in this particular needs to be constantly borne in mind, and when men are on women's wards, or women on men's wards, these patients can be quietly engaged in some remote part of the hall, screened, or at



least provided with a nurse close at hand to prevent as far as possible unseemly conduct and often indecent and homicidal attacks. For sexual excitement often takes the form of extreme violence toward the opposite sex, and sometimes attacks begun in a playful mood may suddenly change to dangerous assault. Knowing that your patients are liable to these manifestations should keep you on guard to prevent them. The ounce of prevention here is earnestly recommended.

Try especially to prevent patients from starting the habit of masturbation. Keeping the genitals scrupulously clean by daily, and if necessary hourly, attention, and keeping the rectum empty, combined with cold sitz baths, and with efforts to divert the patient when eroticism makes itself apparent, are aids to this end. Later, bodily labor sufficient to tire the patient is an aid in conquering the habit.

Excessive spitting, smearing the body and walls with feces and with menstrual blood, tearing clothing and breaking furniture, are all manifestations of run-away impulses, and these can all be reduced to a surprising degree if hygienic measures are faithfully and intelligently applied. Attention to the bowels, not permitting the rectum to remain loaded, and not allowing the patient to have access to the voided evacuations, will also do much to obviate uncleanly habits. Some patients even need to be watched to prevent them from drinking urine and eating feces.

Because of hyperesthesia of the sense organs, excited cases especially should be kept in moderately lighted or even darkened rooms, and all noises lessened as far as possible. Intercourse, in acute stages, should be limited to that of the nurse and the physician, if an ideal treatment can be carried out, and the isolation gradually relaxed as improvement progresses.

In *excited cases*, if the bodily strength and nutrition show but little reduction, exercise under advice of the physician may be encouraged, and will usually furnish a suitable outlet for the superfluous energy of the patient; but in acute stages, as a rule, bed treatment is the most rational and successful. One has to remember that there is a tremendous output of energy in these excited cases, and that this must be compensated for by

generous feeding, without taxing the alimentary system beyond its strength. Milk diet, with the addition of limewater, egg-nogs, broths, jellies, vegetables, and fruits are called for. Animal food and stimulants should be avoided as tending to increase excitability. Highly seasoned food, strong tea and coffee, and tobacco are counterindicated here. These patients need plenty of water; as a rule, five or six glasses a day should be regularly administered in both the maniacal and depressive forms.

At the outset with excited patients warm baths should be administered; at first, a full warm bath of 90° to 95° F. for fifteen minutes, later in the day for thirty minutes, still later for an hour, till, the patient becoming accustomed to them, baths of two to four hours, or even all day, may be administered.

Hydriatric measures are the most successful means we have to allay both the extreme restlessness and the insomnia which are often grave features of maniacal cases. If the heart is weak and the prolonged baths are not well tolerated, warm packs every four or six hours are a good substitute.

As restlessness decreases and baths are discontinued, wheeling the beds into well-aired sun rooms or on verandas, or having the patient sit in an invalid chair on the grounds, are valuable adjuncts to the treatment. Nourishment, an abundance of fresh air, baths, and a sympathetic and judicious attention to the psychic state are the things to be aimed at in the treatment of manic-depressive patients.

It must be remembered that manic patients are generally insensible to cold, to pain, and to fatigue; yet the effects of these agents are just the same on the bodily economy as though the patient sensed them, so that the need for increased nutrition and soothing measures is very great. Because of their insensibility to pain, they need to be watched for other indications of physical disorders that in sane persons ordinarily make their approach known by the forerunner pain.

*Depressed patients* need isolation because of their tendency to put the most unfavorable construction upon every happening. It is bad for them, too, to contrast and compare their condition with that of others. They are painfully affected by the dis-

orders of those about them, are prone to reproach themselves with having brought them about, and tend to refer every possible occurrence to themselves in a most exaggerated way. They should be required to rest in bed and should not be annoyed by well-meant but injudicious advice to exert themselves in overcoming their inactivity, and to "cheer up." As the physical strength improves, a judicious application of stimuli may be made, but it is cruel to tell a weak, dejected patient to "get out of himself," and "cheer up," when he is having all he can do to exist, and to do as well as he does. Platitudes only embitter him, and diversions are likely to irritate rather than help. This is the grave mistake that is made by friends and physicians at the outset of these troubles. The patient is advised to travel, to seek diversion, to exert himself to keep up with the family and social demands when nature is already crying Halt!

One of the most beneficial results to be gained by putting a depressed patient in a sanitarium or a hospital is the separation from family and friends, however great the attachment between them may be. In fact, the greater it is, the greater is the need of removal. Friends cannot forbear from arguing, from urging to action, from trying to amuse, from encouraging, to a degree that only accentuates the already self-centered state. Or, if they do not take this course, they reproach or ridicule, or threaten, or attempt unwise discipline, or force, or use other injudicious tactics. Because of this, and because letters and visits from friends only serve to keep alive the painful sense of the conditions under which the disease developed, correspondence with and visits from friends should be discouraged during the acute depressive stages.

It is a difficult lesson to learn that arguments directed toward delusions are practically useless in most cases. When employed, they should be used by the physician whose business it is to study his patient and learn when the propitious moment has arrived for the use of this measure. It is well for the nurse to remain passive before delusions, ignoring them, changing the subject, and avoiding things that will call up morbid ideas.

In depressed cases, animal food is to be added to the diet already outlined for maniacal cases, and mild stimulants may also be called for if patients are anemic.

Refusal of food may be the result of retardation merely, from inability of the patient to rouse himself enough to lift the spoon to the mouth. This should, of course, be met by regular feeding, due care being given to small mouthfuls, and to leisurely feeding. Save these inactive patients all unnecessary exertion. Let them feel that it is a pleasure to do for them until such time as they acquire strength and energy to do for themselves. Let them know that you recognize that their inactivity is not laziness but illness.

Some refuse food because they believe that their stomachs are gone, or that some part of the alimentary canal is hopelessly obstructed. Arguments will do little good here. If leaving food about where the patient can get it unobserved does not suffice (a device that works in many cases), and the nutrition is suffering markedly, artificial feeding by means of the nasal tube may need to be resorted to.

Anemic, depressed patients who are troubled with insomnia are often greatly benefited by a full meal at bedtime.

Warm baths and packs, as a rule, are beneficial in the depressed forms, but in many of these cases cold baths and packs also work well, especially in the mildly depressed.

Systematic attention should be given to the evacuation of bowels and bladder. The intestinal action is usually sluggish, and fecal impaction and a distended bladder, especially in the stuporous forms, are to be guarded against.

Massage and passive movements are needed to counteract physical inactivity. Anemic patients need a superabundance of fresh air and sunlight at the same time that they need extra clothing and warmth. Select the least-exposed beds for such cases, give them sufficient covering, especially at night, and hot-water bags when necessary; be careful, though, not to weigh them down with clothing, particularly on the chest. Sunlight is markedly beneficial in cases of depression. The common helps at command for the restoration of patients are so likely to be overlooked that at the risk of repetition I wish to remind you of these well-known but too sparingly used remedial measures.

*Suicidal attempts* are not common in manic-depressive insanity, but it is not safe to go on this supposition. Every case of de-

pression, whether it be one of the disease-process we are considering, or that of the melancholia of involution, or a depression accompanying any other mental disease, needs to be under continual surveillance in this respect. There is no knowing when the impulse to end mental suffering may overtake a patient; and the sight of means to do ill deeds makes ill deeds done perhaps before nurses or physicians have suspected that the patient was suicidal.

If the foregoing treatment is intelligently applied, especially the hydriatric measures, there will be little need of employing mechanical restraint, even in the most excited cases, but patients with extreme suicidal or homicidal tendencies and some cases of uncontrollable destructiveness seem to justify it occasionally. Drug restraint is rapidly being dispensed with in all modern hospitals.

The *application of a safety or protection sheet*, or a camisole, or of any sheet or bands to restrain a patient in bed or chair, constitutes restraint. It sometimes becomes advisable in the opinion of the physician to employ these means to prevent a patient from injuring himself or others, or to retain surgical dressings, or to guard against exhaustion or exposure. The employment of any form of restraint, or of seclusion, is only permitted on a signed order of a physician, setting forth the reasons for its application. The restraint order must be turned in daily to the office, with the nurse's signature and statement as to when the restraint was applied and when removed.

If a nurse or a physician will take pains to put himself in a restraining sheet even for an hour, the order or the desire to resort to it for the control of troublesome patients will be long in forthcoming, if the Golden Rule is a part of his practice. It is incredible the amount of discomfort that can be experienced in one of these so-called humane contrivances, even under the most favorable conditions. The writer knows whereof she speaks, having once voluntarily caused herself to be placed in one on one of the quiet infirmary wards. The charge nurse was instructed to apply the sheet and to keep it applied for three hours regardless whether or not the physician changed her mind after being in the sheet for a time — a necessary precaution if anything like a test



of the thing was to be made. It is not pleasant even at this distant date to recall the experience, yet this was undertaken under the most favorable conditions, with nurses ready to keep the ward in its most agreeable condition, ready to attend to the slightest want that might arise, with the patients interested in the experiment, and, by their different ways of acting and commenting about the situation, furnishing means of interest that made the time hang less heavily than it otherwise would. Further than this, the knowledge that the restraint was voluntarily assumed, and that the situation was not without some novelty, contributed an element of interest. Then the experimenter was not a sensitive, overwrought, restless patient, and had none of the many other discomforts to contend with that patients in restraint ordinarily have; yet the amount of discomfort experienced on that moderately warm day in early summer was enough to make the physician an enemy to the safety sheet, except in extreme cases. No one realizes, for instance, how many times a day he brushes away a fly or a stray hair straggling across his forehead, or scratches his nose, or needs to use his hands for countless acts that are attended to automatically, unless he is prohibited in some way. With a tear trickling down the cheek, or the nose in need of attention, or perspiration running down the body, to mention only a few of the things to contend with, one can see how the discomforts of an excited, irrational patient may be increased tenfold.

A new, acute patient should never be placed in restraint till all other means have been faithfully tried, and then only in the presence of the physician.

When restraint is actually deemed necessary, certain things must be carefully looked after. The patient must receive attention as to the evacuation of bowels and bladder before its application, and must be taken up or given the bed pan at least once an hour to afford opportunity to urinate. Nervous persons need to void urine very often, and the recumbent posture seems to favor the secretion of urine; in excited cases great discomfort may be felt in this respect without the patient being aware of what causes it. If sufficient opportunity is not given, certain patients will urinate in the bed, and soon acquire unclean habits.

Whatever restraint is used, it must be examined carefully to see that no chafing or constriction is possible. Wrinkles in the underwear and in the bedding should be smoothed out, and, in restless patients, frequently smoothed out; perspiration should be frequently removed from the body, the face bathed often and dried carefully, drink offered again and again; pains should be taken to keep stray hairs and tossing locks from falling over the face, and flies from lighting on it; in feeding the patient, care should be taken not to spill liquids on the patient's face or neck, and to prevent crumbs and other food from falling down the neck and getting on the chest and under the shoulders. Struggling patients must be closely watched to see that they do not twist about and get in such positions that they constrict their necks or injure themselves in any way. A tendency to rub the chin and face and so cause severe chafing from contact with the strong canvas of which the sheet is made must be guarded against. The danger of bed sores needs to be borne in mind, too, because of the somewhat restricted position of the patient. Ankle straps should not be used.

In the *treatment of paranoia*, aside from providing hygienic care, the chief helps are in furnishing suitable diversion and in removing irritating influences as much as possible. Dr. Frederick Peterson has pointed out that labor often acts as a counter-irritant, and that in action the pent-up nerve force is drawn away from morbid thoughts and feelings, just as in idleness these are intensified and undergo further perversions.

It is well to let these patients talk out their troubles. The interest shown by the listener is soothing to the patient, and once a common ground of sympathy is found, you can the more easily lead the patient away from the topics that engross him to others that will divert him and enlarge his field of interest.

A deluded person hangs painted chains on painted hooks. What we need to do is to put up real hooks for him, and in time he may come to hang real chains upon them.

It will often do a patient good to talk matters over frankly with him, and point out his faulty reasoning, but this course should be left to the physician. And because you hear the physician argue with a patient about his delusions, do not follow

this up with your own arguments, unless the physician explicitly instructs you to do so. An officious nurse, rehearsing the things she has heard the physician say, may undo all the good that occasional suggestions and arguments may do. As a rule, confine your talk to matters of fact, to happenings, to things of interest, and the like, and leave to the physician the arguing.

Some paranoiacs can be helped to a clearer, saner way of looking at things if in some indirect way a hint or a suggestion is dropped. For example, if some such thought as the following could, as it were, accidentally fall in their way: "This is a busy world, and no one really has time to sit right down and hate you. The only enemies we have are those we conjure forth from our own inner consciousness. One thing, we are not of enough account; and the idea that a man has enemies is only egotism gone to seed."

While we are not to combat, directly, insane delusions, we are not, on the other hand, to encourage them. If patients believe that they are kings and queens, or hold other absurd beliefs, it only fixes these the firmer to address them so. A patient in mind has been helped to an attitude of insufferable vanity and conceit largely by the injudicious flattery of nurses, visitors, and even physicians who thoughtlessly humored him by adding to the flattery till his colossal vanity now knows no bounds.

Patients who have delusions about being poisoned are often helped to take sufficient nourishment by the nurse appearing rather indifferent as to whether they take food or not, at the same time that they are given a chance to see their trays prepared from the general supply that does no harm to others. Sometimes the nurse may pour herself a glass of milk and drink it in the patient's presence, immediately pouring milk from the same source in the patient's glass and quietly setting it before her, letting her draw the inference. Or sometimes it works well to let suspicious patients help themselves from the general supply of food as it comes up in the dumb-waiters, before it could possibly be tampered with by any one on the ward.

In the *treatment of epileptic insanity* one of the first things is to regulate the diet. There is need to keep the patient well nourished to counteract the effects of the nervous storms he

undergoes from time to time. Food should be taken regularly and in moderation, and the bolting of food is especially to be guarded against. Meat finely cut up may be allowed at the noon meals. Light suppers only should be eaten. Fried foods, pork, veal, cabbage, and other food difficult of digestion should be prohibited; also alcohol. Many physicians prohibit the use of salt except in very small quantities. The excretory functions of epileptics require careful attention. Copious drinking of water is an aid to this end. Epileptics need to be trained in habits of cleanliness and order. Most of them can be taught some useful occupation, thus giving their activity an outlet. Outdoor labor is especially beneficial in reducing the number of attacks and in lessening deterioration. Much can be done to inculcate self-restraint. We need constantly to bear in mind to safeguard epileptics from injury, and all occupations and amusements must be selected with this in view. Epileptics must not be allowed to climb stepladders, nor to go alone near bodies of water, or near machinery. In their training, patience is a virtue constantly in demand. They need to be under close supervision at night, to guard against suffocation after a convulsion, in case they should so turn as to lie upon the face while unconscious. All sources of local irritation should be removed if possible. Attention to the eyes, the teeth, the nasal cavities, the genitals, and the bowels is very important.

In an epileptic attack the patient should be prevented from falling, if possible, and lowered to the floor; or, if already fallen, should be moved to a place of safety if he is where he can be burned or otherwise harmed. The clothing is to be loosened about the neck, the tongue protected, a pillow placed under the head, and the patient prevented from injuring himself; otherwise he is to be let alone and allowed to sleep, if he will, afterward.

The nurse in care of epileptic patients should keep a record of every convulsion until requested to discontinue it. This record should describe the nature of the aura, its duration, the part of the body first subjected to convulsions, then the order in which the parts are in turn affected; the stage when consciousness is lost, the condition of the pupils, the duration of the tonic and

clonic contractions, and of the coma, and a description of the after symptoms.

In *status epilepticus* prolonged hot baths are sometimes of benefit. Compression of the carotid arteries is also employed if arterial tension is very high.

Some one has said that neurasthenia is a disease of the over-employed, and that hysteria is a disease of the unemployed. In this statement we have a hint as to *what to do for hysterical patients*. Get them interested and occupied. At the same time teach them moderation, especially in the emotional field. At first, in order to correct errors of habit and environment, they will need to be removed from annoying surroundings, and trained to a certain routine in their physical and mental life; but as treatment progresses, they must be trained to ignore irritating stimuli. They must learn to grasp the philosophy of "grin and bear it," and must be stimulated to a certain pride in feeling that they are no longer shorn lambs that need the wind tempered for them; but that they can acquire a certain poise and stability that will enable them not only to withstand but to help others less strong to cope with their difficulties.

When hysterical persons learn that hypersensitiveness is only another name for misery, and that much of what they call "temperament" is only ill-regulated emotional control, they will not be so proud of their impressionable make-ups. They will really desire to train this passionate sensitiveness into strength and calm.

If these patients are in need of bodily upbuilding, the "rest cure" may be called into use; but in many cases just the opposite treatment is requisite.

The *rest cure*, generally speaking, consists of rest in bed, isolation from friends, the prohibition even of letters, over-feeding, combined with hydrotherapy, electricity, and massage. Later, exercise, diversion, and occupation as prescribed by the physician. Throughout the treatment the patient and judicious efforts of nurse and physician are of the utmost importance. One often has to combat the erroneous notion that patients lose strength from lying in bed; that milk does not agree with the patient; that the bowels will not move without



cathartics, and other notions that the wise physician will know how to deal with, but in which he must be seconded by the nurse. Patients taking the modified rest cure even should not be allowed to read in bed, although they may be read to, and may look at illustrated magazines if the physician allows these diversions.

During convulsive attacks the seizures can sometimes be cut short by exerting pressure upon certain parts of the body; for example, the ovarian region. Or a dash of cold water in the face, or a sharp command, may serve to dispel morbid symptoms.

Among the hydrotherapeutic measures, cold spinal douches, or alternate hot and cold spinal douches are of the most value.

Hysterical patients may make many threats and "fake" attempts at suicide, but even such attempts may result fatally from miscalculation or bad management on the patient's part. It is desirable that patients with these proclivities be prevented from obtaining means for making even "fake" attempts at suicide. Reports concerning the hysterical patient should never be made in her presence.

It must be remembered that although hysterical and neurasthenic patients are inclined to exaggerate their complaints, there may be times when they have unmistakable symptoms demanding attention. We must not overlook these conditions because of their hypochondrical tendencies.

In the *treatment of the various neurasthenic and psychasthenic states*, we need to remember that in most of these patients a constitutional weakness of the nervous system, and a faulty education and training, are at the root of the matter. The efforts to help them are, therefore, largely on educational lines. We must build up the body if it needs building up, furnish as favorable an environment as possible, teach the patients the importance of self-control, the value and dignity of labor, and the danger of alcohol and drugs to all neurotic persons.

It is difficult to lay down rules for the treatment of these cases, as each one requires careful personal study, and a course of life laid out and persisted in according to its individual needs.

In cases of overwork we may need to take the matter in hand peremptorily if the patient is so chained to his work that he will not give it up. One cannot be in the show and see it too, and the

person who is overworked, and pushed on by a morbid desire for activity, is often the least capable of seeing that he is going beyond his strength.

It is sometimes difficult to distinguish between true exhaustion and an exaggerated sense of fatigue really induced by the patient's *habit of getting tired*. This habit of tiring on the slightest exertion (some call it laziness) is a fault of character, rather than an evidence of ill health. Such persons need to be taught not to nurse their susceptibility in this direction. We are all in reality stronger than we think we are, but by thinking ourselves less strong than we are we *become* less strong. We make suggestions to ourselves that we are tired, and behold, we *are* tired. One of the ways of helping a person who is given to harmful suggestions would be to talk to him somewhat in this way:—

“You have made a mental representation of your trouble and are trying to live up to it. You are keeping it alive by constantly picturing it to yourself. You are like an actor who is playing a part, and you are playing it so well that you have forgotten that it is not real. If a real actor, playing the part of a man who is to stab himself, should lose his head, he might really do the deed. We have to prevent you from such consequences, and show you that you must not stab yourself with the dagger of the imagination. You must be patiently led out of the state of self-deception. Your auto-suggestions counteract the healthy suggestions one can give you. By repeating these suggestions to yourself often enough they tend to become fixed. Your mental representations, unrestrained by reason, have acquired incredible acuteness, so that you view everything about yourself in a distorted way. Your reason is lame, it limps. It must lean on me for a crutch till it gets strong again.”

It is in some such ways as this that the physician may talk to certain patients, and it is well for the nurse to have an intelligent appreciation of the line along which the psychic treatment is being pushed, although as a rule in all these cases it is better to leave the physician and patient by themselves while such talks are going on, as the mere presence of the nurse is likely to prove distracting or embarrassing to the patient.

The truth of auto-suggestion was long ago stated in the Scrip-

tures: "As he thinketh in his heart so is he." Realizing that a certain thing from which a person suffers is due to his auto-suggestion should not make us any the less sympathetic with him; the fact that the origin of the suffering is in himself does not lessen the suffering. What we need to do is to help him overcome his unfavorable self-suggestions.

We need, then, to teach patients not to attend to depressing thoughts, feelings of fatigue, compulsive ideas, and so on. Tell them they are wiser when asleep than when awake, for in sleep though we sense annoying things (for example, noises), we fail to attend to them, and sleep on; something of this ignoring may be cultivated in our waking state by refusing attention to irritating stimuli. The cases are of course not exactly parallel, but one can work on and perhaps get absorbed in one's work, and so learn to forget feelings of fatigue, or depression, and the like, as unworthy of attention.

In some of the *cases of morbid fears*, the fear almost paralyzes the patient so far as action is concerned. It is a well-known fact that if a person is hypnotized, one drawing a chalk line on the floor can, by merely saying to the hypnotized person, "You cannot step over that line," so affect him that he is powerless to step over the chalk mark, yet his actual muscular power is no whit impaired. A patient may fear that he cannot sleep, that he cannot attend church without fainting, and may have other groundless fears. His belief or fear that he cannot sleep is the chalk line he must step over, and he can do it as soon as he will let go the belief that he cannot step over it.

Many of these psychasthenic cases are beset by countless doubts — doubts as to whether they have locked a door, posted a letter, made themselves understood, or perhaps as to whether they have been immodest, or have injured some one, and when they once begin to doubt, the doubt crowds out everything else, and makes them unfit for anything. A bit of nonsense rhyme in a recent popular book illustrates this aptly:—

"The centipede was happy quite  
Until the frog for fun  
Said, 'Pray, which leg comes after which?'  
Which wrought the mind to such a pitch

He lay distracted in a ditch,  
Considering *how to run*."

Some of these patients tormented by compulsive ideas need tonic treatment, cold rubs, and sprays, forced feeding and good nursing, and when these have done their work the doubts and imperative ideas subside into the background. In other cases the morbid symptoms persist after the body has been brought to a seemingly normal state of health.

Nothing quiets patients with *phobias*, or morbid fears, like the frequently repeated statements that they will not succumb to their fears, and that as they get stronger they will be able to lose sight of what so disturbs them now; in other words, that they will forget they have a hundred feet, and will just run.

In all these attempts to drive away annoying thoughts, or to dispel annoying moods, or to break up undesirable habits, we must remember that the effort of the will will not do it, but that new and absorbing interests and habits will do it by substitution.

In trying to conquer the habit of masturbation where the patient wishes to conquer it and will coöperate, teach him that it is not to be done by saying to himself that he will annihilate the physical in himself. That is folly. He cannot annihilate what is so ingrained, and what is wisely ordained as a part of his very self. He must learn to dignify the physical. Accord to it the proper place in his life. As has often been pointed out, many a monk in the desert has kept his attention fatally fixed upon the physical by vowing that he would annihilate it.

Neurasthenics and psychasthenics have what we may call an overplus of frictional qualities in their relationship with people. In other words, being hypersensitive, and living in their sensations too much, they keep themselves keyed up so high that every relation in life, every experience, furnishes undue excitation, everything enjoyed is enjoyed too keenly, everything suffered is suffered too keenly.

Discouragement at the slow progress in these cases may be met by pointing out to the patients the symptoms which have disappeared. Teach them to dwell on the thought that these have gone, rather than upon that the others remain, but

beware of too much encouragement. What is said should be said in a few words, judiciously, in the patient's presence, but perhaps addressed to another rather than to himself. In this way the patient is put under no obligation to reason and is given no chance to resist the statements, but is merely given a true statement as to the facts of the situation, and a glimpse into the possibilities of adjusting himself in the future to the situations that are at the time so difficult for him. No attempt should be made to force him to the right way of thinking; simply furnish him the material for a correct adjustment, and when the time comes he will be able to use the hints that have been judiciously dropped in his hearing.

Hold the thought of health before your patients as something just ahead of them to be reached out after and worked toward. Make light of their indispositions, not in the sense of neglecting to report them, nor of neglecting to seek to relieve them, but help the patient to see over and beyond them as trivial interruptions in the path to health, not as obstacles in arresting progress. Never tell your patients that their troubles are imaginary. If the physician thinks it wise to do this, that is another matter.

*Cases of Idiocy and Imbecility* are not properly subjects for care in an insane hospital, except when an attack of insanity, in the case of an imbecile, supervenes. These defectives should early be placed in institutions equipped for their care and training. In such institutions some idiots can be taught to talk a little, to stand, walk, move, and dress, and care for themselves to some extent. The senses are trained so that these unfortunates learn to perceive some things and to attain some ability of expression. Those who are susceptible of it are taught games, music, manual labor of various kinds, and some imbeciles of the higher grades learn useful trades, and show surprising skill in certain things. All can be helped to form good habits, and to acquire some degree of self-control, thus preventing or at least lessening the dangerous assaults upon others. Alcohol must be prohibited in these cases.



## CHAPTER XXVIII

### NURSING THE INSANE IN PRIVATE HOUSEHOLDS AND SANITARIA

THE nurse who undertakes to care for the *insane in private households* needs to be even more thoroughly equipped than one who is surrounded by the conveniences, the means of safeguarding the patient, and the moral support of a State hospital. Her resourcefulness and tact, as in private general nursing, are more frequently put to the test than they can ever be in hospital nursing. Clear reasoning, sound judgment, and readiness in action are indispensable qualities.

There is but little that can be said *in favor of home treatment* for the insane, and a great deal that could be said against it. In favor of it we may say that in exceptional families, and under certain favorable conditions, admitting of isolation from the household, yet securing for the patient the comforts and luxuries of a home, it may seem advantageous to try home treatment, but the cases where this fortuitous combination can be found are exceedingly rare. *Against home treatment* we may cite the following conditions to be contended with: The patient can rarely be isolated from his family, yet isolation is conceded to be one of the most important factors in treatment; not isolation from the family alone but from friends and neighbors, and separation as well from the scenes and associations in the midst of which morbid symptoms developed. Even if the members of the family are well poised, calm, and judicious, still *isolation is desirable*, and if, as happens in most families where insanity develops, there are other members who are "high strung," unduly impressionable, and neurotic, the influence is most pernicious both on the patient and on the other members of the household. Usually the more neurotic and unfit the friends are to be helpful to the patient, the more such persons insist

that they are the very ones to direct and help to influence him, to plead with, or argue, or ridicule, or coerce him into normal behavior. A nurse who is confronted by the task of attempting to care for a patient in such a household is indeed to be pitied, for without intending to do it, and without knowing that they do it, the relatives thwart her efforts at every turn. Added to this is the fact that the patient is, as a rule, much more of a tyrant in his own household than he would be in an institution, and will by hook or crook gain his ends, disturb the household's routine, cause constant friction, overrule the friends even when they mean to be firm, try their patience till they sometimes feel themselves on the verge of a breakdown, and in countless ways will prove not only a disturbing influence in the family life, but will, by reason of the unavoidable antagonisms engendered, lessen his chances for recovery.

It is only fair to *consider the good of the many*, as well as the question of depriving one person of his liberty, and one insane person in a family can, by his vagaries and his conduct, so upset the entire household that permanent harm is done to other impressionable members. It may not result in causing them to become insane, but may act in various other harmful ways; in young and imitative children it may exert a most pernicious influence; in sensitive and sympathetic persons it may cause sleeplessness, and other symptoms of ill health, and may partially or wholly incapacitate them for work, often at a time when much is depending upon the quality of their work; in the aged the extra strain may increase arterial changes and bring about mental instability and an earlier decay than would otherwise appear. These are only a few of the baneful effects of attempting home treatment.

Then, too, it is difficult to get nurses outside of hospitals for the insane who are fitted by training to care for mental invalids, however thorough their training has been in other branches of nursing. Furthermore, it is rare to find the family physician sufficiently versed in directing the treatment of such cases to make him willing to undertake them. Certain branches of medicine require special experience and practice; surgery is one of these, mental medicine is another. Skill can only be

acquired by long training in these special lines, and the busy general practitioner seldom has the time to acquire even a theoretical knowledge of mental diseases, such as could be obtained from the literature on the subject, to say nothing of his lack of first-hand knowledge of actual cases.

Another strong reason against home treatment is the poor facilities it offers for guarding against suicide, destruction of property, injury to others, and intentional or unintentional escape or wandering from home. Especially important is it that patients with suicidal or hysterical tendencies, drug or alcoholic habitués, and excited and violent patients, be removed from home care to a properly equipped sanitarium, or to a State hospital.

In the State hospitals especially, the patient experiences at once the wholesome discipline that comes from finding himself one of many, instead of the center of attraction. He immediately has a new outlet for his thoughts, and many of his morbid ones get pushed aside or crowded out just because of the multitude of new impressions made upon him. He soon sees that he is part of a big machine, that law and order prevail here, and that the individuals — patients, nurses, and physicians — have to conform to certain established rules. This is much less galling than to have to submit to rules laid down for him as an individual, and he is less likely to chafe under them than he is under rules enforced by physician or nurse in his own home. Seeing other disturbed patients is often conducive to self-control, and getting an insight into their absurd beliefs and irrational conduct often has its corrective influence upon his own beliefs and behavior. The kind but firm and understanding attitude of nurses and physicians who treat him as a sick man and not as a culprit, has a steadying and soothing effect upon him, and the absence of the anxiety of doting relatives is a most salutary part of the treatment. Relatives can seldom learn that the "watched pot never boils," and find it hard to wait for results that must of necessity come gradually. For this reason it is better for them, as a rule, and far better for the patient, that they meet only at rare intervals during the course of an acute attack. Every alienist can point to cases whose recoveries were seriously

prejudiced and convalescence unnecessarily prolonged, and some which he has every reason to believe have been irreparably injured, by the obstinate insistence of relatives in visiting the patient when he was just at a critical stage where the sight of the relatives, and all that this would call up, was just enough to turn the case on the downward instead of the upward course.

**Home Nursing.**—If a nurse does have to care for a patient in his home, there are many things, as before hinted at, that she will need to consider. She needs to be thoroughly equipped for general nursing, and for the special nursing of these cases—matters already treated elsewhere in this book.

The sanitary arrangements need to be looked after; the choice of the room or rooms occupied by the patient and the nurse, are important considerations; the means for protection from fire, from escape, and from danger to the patient, and to the nurse, are of the utmost importance. Constant vigilance night and day in certain cases is imperative, and only a nurse of wide experience can determine in what cases such vigilance may be relaxed. Some patients that an untrained observer would least suspect are the ones requiring the most thorough surveillance. All medicines and appliances by which the patient could do harm to himself or others must be kept under lock and key. Matches, gas jets, lighted lamps, and razors are continual sources of danger. The windows must be securely guarded, or so arranged that they can be raised only six inches, doors kept locked and the keys in charge of the nurse. A window pane, a tumbler, or a mirror which can be broken at one blow will furnish ample means for self-destruction, and it can all be done so quickly that help, though speedily summoned, comes too late. Patients are often very fertile in attempts at escape and at suicide; a pair of nail scissors or a razor can cause fatal hemorrhage, though the patient has only a few moments in which to act; a twisted nightgown or sheet and something strong enough to hang from are all one needs to strangle one's self, and a patient intent on drowning could do so in a basin of water.

Bolts should be removed from the doors of rooms to which the patient has access, else he may lock himself in a bathroom, for example, and do great mischief or harm to himself, while the

nurse stands helplessly pounding and entreating on the other side of the door.

The *room* where the patient is to stay should be large, airy, cheerful; as quiet as possible, with a pleasant outlook, if it can be arranged; simply furnished, with but few unnecessary things; this last requirement, not only to avoid cluttering and the unrestful feeling of over-furnished rooms, but also to reduce the number of things to be cared for, and to be used as weapons, or to be destroyed, in cases where the patient is violent or destructive. The walls of the room should be restful; if possible, painted or papered with a cheerful quiet color, and free from intricate or tiresome design. Pictures should be few and well chosen. In destructive cases it is sometimes well to procure cheap unframed prints, reproductions of good pictures, and vary these from time to time. Books, magazines, and music may be furnished according to the nature of the case, and the circumstances of the family. Plants and flowers simply and tastefully arranged are almost always acceptable. Bare floors with a few rugs are preferable to carpets and in the case of unclean patients are almost indispensable.

A screen, a lounge, and an easy chair or two, but not a rocker, a bedside stand, or a bed tray, and a commode, are some of the things likely to be needed in most any case of extended nursing.

The nurse will make her value and ability distinctly felt if she shows herself capable of adapting things already at hand to her use, rather than to call upon the family to provide this and that convenience to which she has been accustomed in hospital work.

She needs to be considerate of the domestics but not familiar with them, considerate also of the tastes, customs, and weaknesses of the members of the household; she needs to make them feel that she has come in their midst as a helper, not as one who increases the work and the difficulties under which all are laboring. No nurse worthy of the name will divulge to others matters of which she learns in her profession.

She should see that her vigilance over the patient is as unobtrusive as she can make it so as to reduce as much as possible chafing under restraint. It is important that the patient feel the utmost confidence in her kindness, courage, and sincerity.



If the patient feels that he can impose upon the nurse in any way, or that she is afraid of him, or that she is not to be depended upon, it is disastrous to her influence over him.

It is often annoying to a patient to have the nurse carry on whispered conversations or to talk in a low tone in the room or outside the door with the physician or others; if the patient learns that the nurse meets the physician in some other part of the house, his suspicions may also be aroused. It is well in many cases to leave a note downstairs to be given to the doctor on his arrival, informing him of important conditions and happenings, and so obviate the patient's suspicions.

The nurse needs to be prepared for the unexpected at every turn in dealing with the insane, yet her own work must be carried on with reference to a well-thought-out plan that takes into consideration the physician's directions, the nature of the case and of the environment, the convenience of the other members of the household, and the degree of help that she can count on in the other members. By her own method and calmness, and dignified but tactful authority, she can, as a rule, get the most confused household into its accustomed orderly routine, make friends with her patient, and get his cöoperation, and can so win the respect and confidence of all concerned that they are willing to leave her and the physician to manage the case.

She should so educate the household that they do not require her to talk about the patient. They must learn to cultivate at least an assumed indifference, for it is extremely wearing on a nurse in the few minutes that she gets away from her patient, from time to time, to be obliged to discuss his manifestations and his progress or lack of progress. This is not saying that she is to be so reticent as to render the friends dissatisfied with her services. No rules can be laid down for these things. This is only one of the many instances where tact and discretion are needed.

It will be necessary to enlist the aid of domestics or of other members of the household occasionally, unless two nurses are provided; in doing so, be particular to select those most congenial to the patient. It can only aggravate his symptoms to bring into his presence those toward whom he feels antipathy, even if it is only a temporary antipathy.

In addition to the rules for nursing already laid down elsewhere in this book, the nurse is here reminded briefly of some of the things to be remembered in the various mental disorders she may be called upon to treat. She should, of course, look after the bodily health of her patient, observe and report carefully concerning all symptoms whether physical or mental, and should follow the physician's directions implicitly, except in some unexpected complication arising which requires that she act according to her best judgment, even if contrary to general rules outlined by the physician. In such cases, however, she should notify the physician promptly of the facts in the case.

*Excited patients* are usually mischievous, noisy, loquacious, and violent; they need close supervision; they are changeable in mood and can often be diverted by ready wit and tactful handling, and by yielding to them in non-essentials. Prevent accidents by foresight, avoid angry outbreaks by your own good humor, forbearance, and friendliness. Never attempt to gain your point by deception or by false promises, but avoid unnecessary issues that are known to increase the patient's excitement.

*Depressed cases* need the closest scrutiny, even if no suicidal threats or attempts have been made. All means which might suggest suicide should be kept out of sight. Such patients are to be kindly dealt with, but expressed sympathy in so many words should be sparingly used; it only aggravates their condition. Appearing to ignore their complaints is often wholesome treatment, and your efforts should be directed largely toward quietly furnishing other food for thought without their realizing that you are trying to divert them. They should be kept from self-mutilation also, such as picking the face and pulling out the hair.

*Exhausted patients* need to be generously fed, and need to have the most judicious care to conserve every bit of strength they have. Baths and other means to promote sleep are important parts of the treatment.

*Puerperal patients* need especial care to prevent them from injuring themselves or the baby, provided that it is allowed to be kept near the mother, which is seldom advisable.

*General paretics* need supervision to prevent injuries from their

clumsiness and increasing weakness, and from choking while eating; in the later stages of this disease it is very necessary to guard against bed sores.

*Epileptics* need supervision to keep them from falling against or into things that would seriously injure them; also to prevent their injuring others between paroxysms. They must be carefully watched when eating, lest they bolt their food.

*Delirious cases* of all kinds require continual care, quiet, baths, and diet as ordered. In most patients with delirium a darkened room and the reduction of all sensory impressions to a minimum are needed, but in some patients with *delirium tremens* distressing hallucinations are relieved, as a rule, if a light is allowed in the room. The near presence of the nurse, and her quiet frequent reassurance are very helpful to patients so afflicted. Do not restrain such patients on any account.

*Senile subjects* are especially trying because of their restlessness, usually more marked at night, their uncleanly habits, and their continual desire to go home even when they are at home. They will wander away aimlessly unless prevented. They do not yield to argument or persuasion. A physician now in charge of one of our State hospitals once told me how in the early days of his care of the insane, when, as a medical student, he was acting as nurse to a senile patient in his home, he managed to humor the patient repeatedly in his frequent requests to be allowed to go home, and at the same time get him to take a fair amount of daily exercise out of doors. When the patient's entreaties to go home would be persisted in, his nurse would say, "Well, let's go," and out they would start down the street, letting the patient's inclination direct their course. After sufficient distance had been traversed, the nurse would suddenly halt, divert the patient by calling his attention to some building or other object of interest near by, and in the course of the halt would so manage it that they turned around, so that on starting up again, they were facing toward home without the patient's having noticed the fact. On retracing their steps, and nearing the home, familiar landmarks were casually called to the patient's notice, and on arriving at his own door he would usually be pacified, recognizing it momentarily as home, and then, as a rule,

being sufficiently wearied by his exercise to be willing to rest for a time. Such a course could only be used in senile cases, of course, but it is an instance of the tact that may be practised in such cases. Baths, packs, and other measures noted in the chapter concerning sleeplessness, are useful in caring for senile patients.

Forced feeding and other special nursing measures are only resorted to on advice of the physician. Occupation, amusement, and out-door exercise are prescribed by the physician.

There are certain cases of nervous and mental disease sometimes called *Borderland Cases* that are treated successfully in their homes if nurse and physician possess the requisite skill and resourcefulness so to treat them, and if the friends can be kept entirely away from the patient. In such cases medicine and even general nursing play a very small part; the personality of nurse and physician count for almost everything. A nurse for such patients requires refinement and tact to a considerable degree, broad interests and sufficient education to make her an agreeable companion for her patient who is thrown so exclusively upon her society.

**Nursing in Sanitaria.**—Nursing of patients in Sanitaria differs but little from that in our State hospitals. In the licensed sanitarium the means for protection and the system of espionage are sufficient, as a rule, to relieve the nurse from the anxiety she feels in nursing in private houses devoid of these safeguards. There is, however, more need of vigilance than in the State hospitals.

In a general way we may say that nursing in sanitarium differs chiefly from the larger part of nursing in the State hospitals, in that the patients are all private in sanitarium, come from the more affluent and better-bred classes, and are more exacting and fastidious as to the little things and the niceties of life than are many of your public charges. They are paying for more attention, more comforts, and more luxuries, and even if they themselves do not exact them, their friends usually will, and it is only fair that they receive what they are supposed to receive when their friends place them in these private institutions. Nurses who care for patients in these institutions are therefore of

value in the degree to which they are capable of ministering to the social and psychic needs of their patients, as well as to their bodily needs, and who are conscientious and painstaking to see that their patients get the benefits of the care their friends are trying to secure for them.



## CHAPTER XXIX

### MISCELLANY

**Requirements for the Commitment of the Insane to State Hospitals.** — The commitment of an insane person must be made out on regular blanks provided for the purpose by the State Commission in Lunacy. These blanks may be obtained on application from the office of the Commission in Albany, or from County Clerks, Superintendents of the Poor, Commissioners of Charities, from any of the New York State hospitals, and, usually, from physicians who are legally qualified examiners in lunacy. Any physician in good standing, a graduate of an incorporated medical college, who has been in practice three years, and who has filled out a prescribed blank showing his qualifications in this respect, and filed in the Commissioners' office in Albany a certified copy of the certificate of a judge of a court of record, is a legally qualified examiner in lunacy.

The first thing to do in attempting to get an insane person committed is to find out whether the family physician is a qualified examiner in lunacy. If he is, he will explain the other necessary steps to take; if he is not, he will probably be able to name two other physicians who are legally qualified, and who will be able to counsel the friends further.

The essential steps in the procedure are as follows:—

A petition must be made to a judge or justice of the county court, or of the Supreme Court; it must be made on the prescribed blanks, and must set forth clearly the reasons for believing that the person in question is insane, and also those which lead you to ask that an order for his commitment be granted.

This petition may be made by any one with whom the alleged insane person may reside, or at whose house he may be, or by the father, mother, husband, wife, brother, sister, or the child, of any such person, or by any overseer of the poor, or a super-

intendent of the poor of the county in which any such person may be.

This petition must be accompanied by the certificate of lunacy made out by two qualified physicians who have jointly examined the case, and it must be within ten days next before the granting of the judge's order.

The law also provides that a notice stating that such an application is about to be made, be served personally at least one day before making said application upon the person alleged to be insane, or, in case the one who makes the petition is an overseer or a superintendent of the poor, notice must be also served upon the husband or wife, father or mother, or next of kin, of the alleged insane person, if there be such known to be residing within the county, and, if not, upon the person at whose house the alleged insane person may be. This part of the law, however, may be waived by the judge, if he thinks the proof adduced is such that the patient is unquestionably insane and in need of hospital care, and especially if in the opinion of the physicians, the notice would be injurious to him by unduly exciting and alarming him, or if, for any other good reason, it seems best to dispense with personal service. Or, he may, instead of requiring personal service, direct that notice be served upon some near and responsible relative.

The judge may demand a hearing upon his own motion or upon the request for the same by the alleged insane person himself, or any of his relatives, or a near friend who asks for it in behalf of the alleged insane person. He may then examine the person alleged to be insane, and take the testimony bearing on the case, and, according to his findings, discharge or commit the person as he sees fit.

If he sign the order of commitment, the superintendent of the hospital to which the patient is committed is then to be notified of the fact, so that provision may be made at once for the transportation of the patient.

The blanks for the petition, for the certificate of the physicians, for the judge's order, and for the other matters mentioned, are all bound together in one compact pamphlet that, as has been said, may be had on application at the places previously named.

The certificate is outlawed if five days have elapsed from and inclusive of the date of the judge's order, before the patient is conveyed to the hospital to which he has been committed.

The commitment papers must be presented to the superintendent, or to the person in charge of the institution, before or at the time that the patient is brought to the institution.

The costs of commitment of a poor or indigent person, and the expense of providing proper clothing, shall be a charge upon the town, city, or county securing the commitment. In the case of persons not poor or indigent, the costs are charged to his estate or are met by persons liable for his maintenance.

**Emergency Cases.** — If a case be particularly urgent, and require immediate hospital care, there is a provision in the law whereby the insane person can be temporarily admitted to the hospital if accompanied by the petition and the physicians' medical certificate. Meanwhile prompt steps must be taken to secure the judge's order, as before explained. The patient may be detained at the hospital five days, pending the judge's order of commitment, but in order to do this, the petition and the certificate of lunacy, and the patient's condition itself, must clearly prove such a procedure necessary.

With these rigid precautions that the Insanity Law makes obligatory, it is easily seen how improbable it is that persons not insane can be committed to hospitals for the insane. Troublesome as these requirements are to carry out, a little reflection will enable one to see the wisdom of safeguards that provide against the unjust commitment of any one to our State hospitals, or his unjust detention therein.

**Clothing of Patients.** — Public patients are required to be dressed in a new suit of apparel throughout when brought from a jail or an almshouse, but when brought from their homes this requirement need not be rigidly enforced by the attendant, if he finds on examination of the clothing owned by the patient that it is clean and suitable, and that there is no apparent danger to be feared from contagion of any kind. Between the last day of October and the first day of March a shawl, cloak, or over-

coat, and gloves or mittens must also be provided. This clothing must be furnished by the county from which patients are committed, unless provided by their friends.

**Conveyance of Insane Patients to State Hospitals.** — When nurses or attendants are sent to convey patients to the hospital they need to get explicit directions as to where they are to go and for whom, and what trains, roads, changes, and means of transportation they are to depend upon, both for going and returning. They need to get from the steward sufficient money to defray the probable expenses, and to keep an itemized account of all expenses incurred and turn in the same on their return.

They should be plainly and neatly dressed and should on all occasions seek to make their demeanor and way of meeting trying situations such as will reflect credit on themselves and on the hospital they represent.

On arriving at the place where the patient is sojourning, they are first to inquire for the certificate, and are to ascertain whether the commitment is legal or not. It is not legal (1) if five days have expired from and inclusive of the date of the judge's order; (2) if the date of the judge's order is more than ten days after the date of the medical examination, counting the day of examination as one day.

If the nurse is satisfied that the commitment is legal, she is then to see the patient, and a responsible relative or friend from whom she is to inquire briefly concerning the mode of onset, and the manifestations that led to the commitment. In some hospitals it is customary to send a pamphlet to the friends of patients, giving information likely to be needed by them, and in turn telling them what information is likely to be needed by the physicians, to insure a proper understanding of the case. One of these pamphlets, when provided, is taken by the nurse, and its use explained, and the friends are asked to visit the hospital, if practicable, within a few days, or to send the family and personal history and onset of the disorder by letter at their earliest convenience. If the nurse makes any inquiries herself, as will sometimes seem prudent to do, she should take care not to offend by what would seem curious or impertinent questions.

If the patient is in an almshouse, and this fact was not known before leaving the hospital, the nurse is to communicate by telephone or telegraph with the hospital before bringing the patient. She is also to do this if the patient is over sixty years of age, or has been feeble-minded since childhood, or is in what seems to the nurse too critical a condition to be moved, or is unmistakably not insane. Patients with contagious diseases are on no account to be brought to the hospital. She may also refuse to take the patient if the patient is not clean, and if suitable clothing is not provided. As a matter of fact, however, many a nurse accustomed to caring for this class of patients can go into a home where all is confusion and where the friends seem utterly unable to render the patient clean and tidy, and can soon put her in a proper condition; and while this is not required of the nurse, most nurses are humane enough to prefer to do it rather than leave the friends in the lurch, and incur the extra expense of returning to the hospital until the patient's body and clothing are suitably prepared, or to sit around idly waiting while the friends attempt to do work that she could at least lighten by a helping hand.

If the near relatives seriously object to the removal of the patient, it is well to communicate with the hospital before insisting on the removal.

The patient should leave his money and valuable jewelry at home; wedding rings as a rule may be allowed, and the patient may also be allowed to bring a dollar or two of pin money if so desired. If the friends wish more money or valuable belongings to accompany the patient, it must be made clear that it is done at their risk. The nurse should give the patient's friends the name and address of the superintendent of the hospital, to whom all letters of inquiry are to be addressed, but should make them understand that they may communicate directly with the patient. The name, address, and relationship of the nearest relative as correspondent is to be secured by the nurse.

The nurse's manner of approaching and greeting the patient should be quiet, friendly, sincere, and tactful. Patients are quick to detect insincerity, palaver, indifference, or unkindness; but if approached in the right way the instances are compara-



tively few where an experienced attendant cannot mollify irascible ones, overcome resistance, and persuade the patient, since it seems best to take this step, to come willingly, or at least unresistingly, to the hospital.

There will be occasional cases where persuasion and tact are unavailing. Such must be dealt with by firmness, unvarying kindness, and if necessary by force, never by deception. You will have to combat this tendency to deception in the friends. They often have an elaborate scheme arranged for deceiving the patient, sometimes one in which the family physician even has connived, but your duty is clear. You must not be a party to such deception. You are to explain to the patient as tactfully as you can that she is ill, if not in body, then in mind; and that a hospital for just such cases is the place where she will be most likely to get well, and you are sent to take her there. Some patients will be glad to come; others will be too excited or stupid to appreciate your explanations; still others will violently object.

If you have any doubts about being able to handle the case alone, get some judicious person to accompany you a whole or a part of the way, as necessity demands. You will usually find, however, that the railroad officials will render you all the help necessary, and in many instances the patient's behavior is far better as soon as she gets away from the friends and finds herself with a kindly disposed stranger who lets her understand that she considers whatever is reprehensible in her behavior as due to illness, to a sick mind, and not to willfulness or depravity.

On the journey attention should be paid to the patient's comfort; to the evacuation of bowels and bladder; to nourishment and rest if the journey is a long one; and to protection from cold if the weather is severe. See that drinking water is offered to excited and feverish patients; that tactful means are used to divert or entertain certain ones; and in every way strive to inculcate self-control and seemly conduct. Discourage the curiosity of fellow-travelers by quiet dignity. Sometimes you will meet with most impertinent prying into your own and the patient's affairs. Treat such persons with courteous but dignified rebuffs. Accept friendly offers for assistance if you need them;

and, if you do not, your thanks are always due the one making the offer.

You will generally find that it is better to take the front seat in a car with an excited patient, for if she is inclined to be hilarious, and is sitting in the rear of the car, the ill-concealed curiosity and amusement of those sitting in front, as they turn to stare at her, only serve to make her actions still more extravagant. It is well to have with you an illustrated magazine, as the pictures will often serve to divert a patient inclined to be noisy.

On no account are you to leave the patient alone an instant. Accompany her to the water-closet, exercise the greatest care in getting out of trains, boats, and carriages and, without letting your surveillance be apparent or annoying, see that it is constant. One case in mind made the excuse of going to the water-closet, and jumped from the car window while the train was in motion, thus committing suicide, when probably escape only was intended.

Patients should be searched carefully for drugs or concealed weapons before taking them from home. Be lenient with patients about little belongings which they wish to bring — photographs, a favorite book or two, etc.; but as a rule you should not burden yourself with any luggage except a hand bag containing the things immediately needed, as you should be free to give your entire attention to the patient. If the checking or care of luggage is likely to be of much trouble to you, by reason of changes, and you have in charge an obstreperous or a suicidal case, it is better to have the luggage sent on by express than to undertake to look after it.

Try to make the friends understand, more by what you are than what you say, that the patient is going among friendly disposed persons who will do all that they can to care for her and aid in the recovery. By your own kindly manner you can do much to lessen the grief of those who are obliged to consign their friends to the care of strangers and to the wards of a State hospital.

Seek to allay the fears of patients who seem to dread the entrance to the hospital by kind and reassuring words on the journey and by practical efforts on their arrival, to the end that an event so trying shall be made as easy for them as possible.

On your return to the hospital, turn in your report of expenses to the steward, and your report to the physician of the environment of the patient, her behavior at home and on the journey, and any facts that you learned of herself or family that have any bearing on the case, together with the name and address of the correspondent for the patient.

**Care of the Dying and Dead.** — It is the nurse's duty to see that a dying patient has an opportunity to receive the last sacraments, or at least to see a clergyman, if he so desires. In the case of Roman Catholics a priest should be sent for whether the patient is conscious and desires to see one, or refuses, or is even unconscious.

In hospital practice there will be no difficulty in summoning a physician to the bedside of a dying patient whenever a change for the worse is observed, and this should always be done. In private practice the physician should be informed if death seems approaching, and if he does not arrive in time, he should be notified at once when death occurs.

The nurse should give the patient a chance to see his friends if they can be summoned while he is still conscious. Everything should be done to make the last hours as comfortable as possible, and the nurse should stay with the patient to the end.

The *signs of approaching death* are what is known as the Hippocratic face — sunken eyes, a sharp nose, collapsed temples, cold ears, with the lobes turned outward, the skin of the forehead parched, the face livid, lead-colored, or brownish — cold extremities, clammy skin, and steadily failing heart's action, perhaps muscular twitchings and stupor, and the ominous "death rattle" in the throat.

The dying patient should always be removed from the ward if practicable; if not, he should be carefully screened, and the other patients spared as much as possible from seeing and knowing about the event.

The nurse should note and record the exact time of the death, and this, with the full name of the patient and the ward location, should be written on a paper and pinned to the nightgown on the patient, if the body is sent to an undertaker, and on the winding sheet, if the body is sent to the morgue.

*When the end comes*, straighten the limbs, close the eyes, put in artificial teeth, if such are worn, and then, if friends are there, leave them alone with their dead for a while. If the eyes do not remain closed, insert a wisp of cotton under each upper lid and pull the lid well down over it. After that, wash the body with soap and water and a 1 to 40 carbolic solution. Pack the nostrils, mouth, rectum, and vagina with cotton, and put on a diaper. In packing nostrils and mouth, be particular not to distort the features. Cover bruises and wounds with cotton and collodion. Tie the feet and knees together with a broad bandage, support the chin by a roller bandage placed under it, resting against the chest, but softened at the end with cotton, so the pressure will leave no mark on the chin, and fold the arms across the chest. Arrange the hair neatly in its accustomed way, pay particular attention to the finger and toe nails, and dress the body in nightgown and stockings. Cover the body with a clean sheet, put the room in order, and remove all signs of illness.

*The positive signs of death* are very few. Absence of breathing is not a sure sign, for this takes place during fainting, or when a person is in a trance. Breathing may be so faint as only to be detected by the most delicate of tests. Hold a hand mirror in front of the mouth. If it becomes moist, respiration, though feeble, is still going on. The apparent cessation of the heart beat is not to be relied upon unless the physician, listening with a stethoscope, fails to hear it beat. It must be remembered, too, that coldness of the body and rigidity are observed in cataleptic states. It is especially important in cases of what appear to be sudden death to make sure that the person is really dead. The stethoscope test has already been mentioned. The circulation is tested by tying a string tightly around a finger; if the tip becomes blue, life is still there; but if there has been severe hemorrhage, it may not show blue, even if the person still lives.

In a doubtful case, the physician sometimes gives a hypodermic injection of ammonia. If a red spot forms, it shows the person to be alive. Or if a needle be thrust in the flesh, and the part bleeds, you may know life is not extinct. Another test is to hold the hand in front of a bright light. If the normal pink

line observed between the fingers with the hand so held is replaced by a yellow line, it is said to be a sure sign of death.

*Rigor mortis* is the rigidity of the muscles that comes on at variable periods after death. It shows itself in the jaw first and spreads downward. In some cases it comes on ten or fifteen minutes after death, in others from twelve to twenty-four hours. It disappears in the same order, leaving the body limp and utterly relaxed. Another probable sign of death is the lividity seen in dependent parts due to congestion of the blood in the capillaries.

In most cases after death the body gradually cools, being quite cold in from six to twelve hours, but in certain diseases the bodily temperature remains high, or continues to rise for some time after death, *e.g.* cholera, yellow fever, and general paresis.

Putrefaction is the conclusive proof that death has taken place.

If a person dies of some infectious disease, the body should be bathed in a strong disinfectant, and wrapped in a sheet wrung out of a 5% carbolic acid solution, and the sheet kept wet by sprinkling from time to time. The funeral should be private, and in private nursing the nurse usually stays with the family to superintend the fumigation of the room.

**Autopsies.** — The trained nurse's attitude toward the question of autopsies should never be such as to dissuade the friends from consenting. Realizing as she must how every autopsy adds to the sum of medical knowledge, she should at least not discourage, if she cannot encourage, the friends to give their consent. The nurse should, of course, never discuss the findings of an autopsy, any more than she should the details or the treatment of a case. It is the province of the physician to enlighten the relatives as to the findings; others have no right to know the facts unless the friends choose to furnish them.

Autopsies are best done soon after death, before putrefactive changes take place, and before the undertaker embalms the body. The body is prepared as previously described, except that no clothing is put on but the diaper, after which the body is wrapped in a sheet.

The hair of women patients, if long, is to be parted over the top of the head in a straight line from ear to ear, and each portion



brought well away from the part and braided, one braid hanging forward and one backward, or, still better, one being coiled and pinned securely in front of the part, and the other similarly coiled on the other side of the part. By this arrangement the incision in the scalp is easily made and the hair is kept clean and out of the way.

If the autopsy is to be performed in a private house, the carpet should be protected with oilcloths, rubber sheets, or old papers. There should be a stand for instruments, three wash bowls, two pails of water, hot and cold, old towels, and a large sponge or two. There should be oakum or cotton batting to pack the cavities, and some small, wide-mouthed bottles for specimens. The physician will usually bring these, as well as his instruments, needles, and suture material.

The nurse should remove all blood stains from the body or elsewhere, should remove all signs of the autopsy, put the room in perfect order, ventilate it thoroughly, and if necessary, burn a little coffee on a shovel to dispel the odor. The patient's body should then be dressed in nightgown and stockings, and covered with a clean sheet, to be further attended to by the undertaker.

Patients dying in State hospitals should be clothed with the best of their own clothing if it is good enough, or if not, with a burial outfit provided by the State.

As soon as the patient's clothing has been returned from the laundry, it and all the rest of her clothing and belongings should be packed and listed and sent to the office for shipment to the friends. Jewelry, money, and other articles in the safe belonging to the patient should be sent at the same time.

If the relatives visit the hospital afterward and ask for the nurse, the latter should take pains to recall as comforting things as she can to tell them about, but should omit distressing details. As to information concerning the medical aspect of the case, the nurse should refer the friends to the attending physician.

## INDEX

- Abdomen**, preparation for examination, 135; operations on, 189, 190, 192-193, 194-195.
- Abdominal compresses**, *see* Compresses.
- Ablution**, 94-95.
- Abortion**, threatened, 204, 205.
- Abstinence symptoms**, 315-316, 359. *See also* Drug habitué.
- Abusive patients**, 265-266.
- Accidents**, *see* Emergencies.
- Acid burns**, 154; poisons, 163.
- Acts, impulsive**, 302, 318, 340. *See also* Ideas, imperative.
- Acute mania**, *see* Manic-depressive insanity.
- Addison's disease**, 141.
- Administration of Medicines**, *see* Medicines.
- Adornment of wards**, *see* Wards.
- Affusion**, 96, 171.
- Aged patients**, *see* Senile insanity.
- Air**, composition, 61; nature's means of purification, 62. *See also* Ventilation.
- Alcohol**, use of, in employees, 19; administration to patients, 19, 27.
- Alcoholic delusional insanity**, 312-314.
- Alcoholic habitué**, *see* Drug habitué.
- Alcoholism**, acute, 310-311; chronic, 311.
- Alienation**, 287.
- Alkali**, burns, 154; poisoning, 163.
- Almshouse**, patients conveyed from, 394.
- Altruist**, 251, 274.
- "Americanitis"**, 344.
- Amnesia**, 297.
- Amusement of patients**, 22, 29, 33, 51, 58-59, 210, 213-222, 354. *See also* Occupation of patients.
- Anemia**, 97, 98, 108, 225, 307, 368.
- Anesthesia**, 186-191, 206, 303, 304, 366.
- Anesthetics**, 149, 186; local, 191.
- Angina pectoris**, 103, 181.
- Anorexia**, 136.
- Antidotes for poisons**, 163.
- Antiseptics**, 183-184. *See also* Disinfectants.
- Antitoxin in diphtheria**, 173-174.
- Aphasia**, 303.
- Apomorphia**, 162. *See also* Emetics.
- Apoplexy**, 147.
- Appearance of patients**, general, 131-132.
- Appendicitis**, 178-179, 191. *See also* Abdomen.
- Application for State hospital service**, 1, 2.
- Artificial feeding**, *see* Nasal feeding.
- Artificial respiration**, 149, 189, 206.
- Asphyxia**, 148-149.
- Association of ideas**, 284, 286, 290, 335.
- Asthma**, 179.
- Attendants**, defined, 2; requirements for applicants, 2; wages of, 3-4; clothing, 2; time off duty, 2, 3; vacation, 3; resignation, 2; dismissal, 2, 4; transfers, 4; duties of, 5; new, *see* Probationers. *See also* Nurses.
- Attention**, power of, 240, 241, 242, 245, 270, 347, 348, 354-355.
- Aura**, 337-338, 373.
- Automatic acts**, 211, 236, 253-254, 302, 305.
- Automatic intelligence**, 237.
- Autopsies**, foreign bodies found, 137; nurse's attitude toward, 399; preparation for, 399-400; in private houses, 400.
- Auto-suggestions**, 376-377.
- Bacilli**, 176. *See also* Bacteria.
- Bacteria**, 152, 174, 183-184.
- Bandaging**, 185.
- Bathing of patients**, 32, 40-41, 46, 47, 89-92, 96.
- Baths**, uses of, 89; tub, 91, 172; remedial, 92-105; medicated, 112.
- Beards of patients**, 32, 82, 176.
- Bed**, airing, 68, 81; care of, 70, 71, 80; cradles, 78-79, 170; changing clothing of, 75-77, 83, 84-85; bedding, 71, 74, 75, 76, 79; making, 74-75; pan, 85, 171, 175. *See also* Vermin.
- Bed patients**, care of, 4, 30, 32, 73, 75-81, 85, 89-91; conveniences for, 78-79, 83-84, 87; feeding of, 117-119. *See also* Toilet of patients; Bed sores.
- Bed sores**, 38, 85, 86-88, 105, 170, 360, 387.
- Bee stings**, 152.
- Belongings of patients**, 12-13, 32, 42, 57, 80, 394, 396, 400. *See also* Clothing of patients; Valuables.
- Besetting sins**, 263, 291.

- Bible, quoted, 9, 377.  
 Birds, books concerning, 218.  
 Bites, from insane patients, 152; from insects, 152.  
 Bladder, attention to, 43, 84; irrigation, 111-112, 122, 359, 360. *See also* Cystitis.  
 Blows on head, 148. *See also* Scalp wounds.  
 Body and mind closely related, *see* Mental states and bodily reactions.  
 Borderland cases, 388.  
 Bowels, attention to, 43, 84, 136, 180, 368. *See also* Feces; Enemata.  
 Brain, 237, 238, 245, 260, 274, 277, 282-283, 286, 347.  
 Brand bath, 100, 101-102.  
 Breasts, care of, 204, 207.  
 Bright's disease, 141, 181.  
 Bronchitis, 179.  
 Bruises, 151.  
 Bulimia, 136, 331.  
 Burns, avoidance, 129, 142, 360; kinds and treatment, 152-154.  
 Burroughs, John, essays, 218; alluded to, 266.  
  
**Call, Annie Payson**, quoted, 264-265.  
 Camisole, *see also* Mechanical restraint.  
 Carbohc acid burns, 154.  
 Care of new-born child, 206, 207-208, 386.  
 Care of pregnant woman, 204.  
 Catheterization, 122.  
 Catholics dying, 397.  
 Cauterization in hemorrhage, 158, 159.  
 Centipede, doubting, 377-378.  
 Cerebro-spinal fluid, *see* Lumbar puncture.  
 Cerebro-spinal meningitis, 172.  
 Certificate of lunacy, 391.  
 Cervix operations, after care, 204.  
 Changing beds, *see* Beds.  
 Charge attendants, wages of, 3. *See also* Charge nurse.  
 Charge nurse, wages of, 3 (*see also* Charge attendants); duties, 5, 22, 23, 26, 27, 28, 32, 39, 49-59, 66, 70; efficiency, 49; executiveness, 32, 49-50, 68, 70; influence of, 50-51, 58; tact of, 50-52, 55, 56; hostess of ward, 51-52; instruction of subordinates, 52-53, 55-56, 82; patience with beginners; 52-53; qualifications, 54, 55, 59, active interest in welfare of patients, 51, 58; report of conditions, 54, 55; keeping of memorandum, 54.  
 Chest, preparation for examination, 133-134; compress, 106-107.  
 Chilblains, 156.  
 Choking, treatment, 149-150.  
 Chronic patients, care, 7, 8-11, 14, 353-357; stimulation, 9; improvement, 9-10; humoring, 11-14; tact in management, 10-12; forbearance with, 12-13.  
 Chronic service, 8, 15.  
 Chronicity, avoidance of, 7, 8, 11, 20, 21.  
 Circular insanity, 328. *See also* Manic-depressive insanity.  
 Civil Service examination for attendants, 2.  
 Classification of mental diseases, 308.  
 Clothing, of patients, 32, 33, 38, 42, 57, 200, 392-393, 400; changing, 75-78; removal of, 84-85, 154, 164-166; on fire, 154.  
 Cocainism, 316-317, 359-360. *See also* Drug habitué.  
 Cogitations, 247.  
 Cognition, 247.  
 Cold, *see* Exposure to cold.  
 Cold bath, 92-93; cold full bath, *see* Brand bath.  
 Cold pack, 98-100.  
 Cold rub, 98.  
 Collapse delirium, 309.  
 Collecting propensity, 12, 13, 80. *See also* Ownership.  
 Coma, 144-148, 156. *See also* Unconsciousness.  
 Commission in Lunacy, *see* State Commission in Lunacy.  
 Compresses, 105-108; throat, 105-106, 189; chest, 106, 107; abdomen, 107; hot fomentation, 107-108.  
 Compulsive ideas, *see* Ideas.  
 Compulsive insanity, 345-346. *See also* Impulsive insanity.  
 Conceptions, 241.  
 Concepts, 284, 285, 286, 296. *See also* Ideas.  
 Condition of patient on admission, 36-38.  
 Confinement cases, *see* Pregnancy. *See also* Puerperal insanity.  
 Conscience, 262.  
 Consciousness, 241, 245, 247, 257, 259, 299, 309, 326, 334, 343.  
 Constipation, 136, 137, 164. *See also* Enemata.  
 Constructive instinct, 271.  
 Consumption, *see* Tuberculosis. *See also* Phthisis.  
 Contagious diseases, 168-174, 394. *See also* Infectious diseases.  
 Continuous bath, 104-105.  
 Contusions, 151.  
 Conveyance of patients to hospitals, 393-397.  
 Convulsions, 282-283. *See also* Brain.  
 Convulsions, children, 102; epileptic, 142, 145, 233, 337-338, 373; hysterical, 146, 375; organic brain diseases, 304-

- 305; puerperal, 204, 206; uremic, 102, 145-146, 181.
- Copper sulphate, 162. *See also* Poisoning.
- Cord, tying, 205. *See also* Pregnancy.
- Correspondence, of patients, 44-46; about patients, 25, 394, 397.
- Corrosive poisons, 163.
- Cortex, *see* Brain.
- Cough, report of, 134.
- "Cranks," 335, 337.
- Crumbs, 80, 86, 87, 119, 371.
- Curiosity, instinct of, 269-270, 319, 352.
- Custodial care, 350.
- Cut throat, 159-160.
- Cystitis, 105, 109, 137. *See also* Bladder.
- Damocles**, sword, 334.
- Danger signals of insanity, 293.
- Dead, care of, 398.
- Deaf-mutism, 303.
- Death, from contagion and infection, 169, 399; signs of, 398-399.
- Deception of patients prohibited, 31, 34, 395.
- Defective mental states, *see* Idiocy and Imbecility.
- Delirious mania, 329, 332. *See also* Delirious patients; Manic-depressive insanity.
- Delirious patients, 96, 98, 118, 127, 172, 175, 357, 358, 359, 387. *See also* Exhaustion psychoses; Delirium tremens.
- Delirium tremens, 233, 311-312, 359, 387.
- Delusions, 121, 123, 142, 284, 290, 291-292, 295, 298, 307, 312, 313, 317, 321, 324, 335, 357, 368; nurse's attitude toward, 11-12, 31, 47-48, 221-222, 335, 351, 367, 372.
- Demented patients, 67, 91, 118, 129, 149, 155, 156, 209, 270, 271, 302, 303, 304, 305, 306-307, 353, 354.
- Dementia paralytica, *see* General paresis.
- Dementia præcox, 133, 317-319, 354, 360. *See also* Demented patients.
- Dementia, senile, 325-327; terminal, 300.
- Demulcents, 163.
- Depressed patients, 31, 91, 115, 118, 222, 246, 249, 258, 260, 270, 276, 285, 288, 300, 301, 302, 306-307, 308, 329, 362, 363, 366, 367-368, 386 (*see also* Melancholia); manic-depressive insanity, 333-334.
- Destructive instinct, 271.
- Destructiveness, 20, 85, 271, 355.
- Deteriorated patients, *see* Demented patients.
- Diabetes, 98, 138, 181-182, 184.
- Diarrhea, 105, 109, 136-137. *See also* Dysentery; Bowels.
- Dining room attendant, wages of, 4; 113-116.
- Dining rooms, 64, 113.
- Diphtheria, 105, 173-174. *See also* Antitoxin.
- Disinfectants, 127, 168, 183, 184.
- Disinfection, 168-169, 183, 184.
- Dislocations, report of, 38, 166. *See also* Fractures.
- Disorientation, 299.
- Distractibility, 330.
- Do instead of dream, 255, 278, 280-281, 289, 360.
- Doubts, morbid, 377-378.
- Douche, 108; Scotch, 108; vaginal, 122, 192, 199, 203, 205; nasal, 162.
- Dreams, 224, 233, 289-290; dreamy states, 299, 333, 339, 341, 343. *See also* Epilepsy; Hysteria.
- Dress of patient, observation of, 131.
- Dressing basket, 57-58.
- Drip sheet, 97-98.
- Dropsy, 180. *See also* Heart.
- Drug habitué, 191, 225, 290, 314, 359, 360, 382.
- Dual personality, *see* Multiple personality.
- Du Bois, Patterson, quoted, 352.
- Dust, 68, 69, 70, 194.
- Duties of nurses, 5. *See also* Rules for nurses.
- Dying, care of, 397.
- Dysentery, 120, 174-175. *See also* Enemata; Bowels.
- Ecchymosis**, 151.
- Economy of State property, 19, 54.
- Ego, 247-249, 286; alterations of, 131; complexity of, 248-251.
- Egoist, 251.
- Elated patients, *see* Excited patients.
- Eliot, George, quoted, 6, 291.
- Emergencies, 27, 28, 142-167, 186, 193, 205; guarding against, 142-143; report of, 143.
- Emergency commitment, 392.
- Emetics, 162.
- Emotions, 132, 240, 274, 276-277, 278, 282, 284-285, 287, 288, 300-301, 318, 319, 322.
- Employment of patients, *see* Occupation of patients.
- Endocarditis, 180.
- Enemata, 120-121, 151, 170, 171, 179, 186, 191, 199; nutrient, 121-122. *See also* Bowels.
- Enteritis, 178. *See also* Diarrhea.
- Enteroclysis, *see* Intestinal irrigation.
- Environment, influence of, 246, 260, 261, 270, 275.
- Epilepsy, 91, 118, 142, 145, 146, 149,



- 233, 302, 337, 387. *See also* Convulsions.
- Epileptic insanity, 337-341; treatment, 372-373. *See also* Epilepsy.
- Epistaxis, 161-162.
- Erotic patients, 364-365. *See also* Masturbation.
- Eruptive fevers, 169.
- Erysipelas, 174.
- Examiners in lunacy, 390, 391.
- Excited cases, 120, 207, 219, 246, 260, 270, 276, 285, 296-297, 307, 308, 363-366, 370, 386, 396. *See also* Manic-depressive insanity.
- Excreta, disinfection, 168, 175, 178, 184.
- Exercise of patients, 22. *See also* Gymnastics.
- Exhaustion psychoses, 170, 309-310, 357, 386. *See also* Toxic psychoses.
- Exposure to severe cold, 33, 156-157.
- Faculties of mind**, 237-238, 240, 246. *See also* Mind.
- Fainting, 144, 157.
- "Falling sickness," *see* Epilepsy.
- False heliefs, *see* Delusions.
- Fear, instinct of, 269; morbid, 37, 43, 233, 323, 345-346, 377-378.
- Feces, 121, 137, 164, 168, 175, 178, 179, 184, 365. *See also* Bowels.
- Feeble patients, 32, 36, 40, 75-77, 81, 83, 90-91, 93, 95, 96, 98, 118, 142, 232, 233, 368.
- Feeding, by persuasion, 123, 361; mixtures, 125, 126; forced, *see* Nasal feeding.
- Fénelon, quoted, 257.
- Ferns, hook concerning, 218.
- Fevers, treatment of, 170-172; rheumatic, 175, 180. *See also* Cold pack.
- Fire, danger of, 69; clothing on fire, 154; in hospital, 154-155; drills, 155; protection against, 234.
- First impressions, received by patients, 34-35, 41.
- Fishhooks in flesh, 152.
- Flight of ideas, 286, 297.
- Floors, care of, 69.
- Flowers, books concerning, 218.
- Fomentations, 107-108.
- Food, serving of, 11, 12, 32, 113-119, 136.
- Foot bath, 112.
- Forced feeding, *see* Nasal feeding.
- Foreign bodies, esophagus, 137, 149-150; pharynx, 149; stomach, 137, 150; intestines, 137; vagina, 137, 150; urethra, 150; rectum, 137, 150.
- Foreign patients, 214.
- Fractures, 85; report of, 38; signs of, 164; management, 164-165; in aged cases, 363. *See also* Dislocations.
- Friends of patients, 14, 24-25, 34, 117, 361, 367, 380-383, 393, 394, 396, 397, 400.
- Frost bites, 156.
- Fumigation, 66, 169.
- General anesthesia**, *see* Anesthesia.
- General paralysis, *see* General paresis.
- General paresis, 86, 91, 118, 149, 297, 320-323, 360, 386-387, 399.
- Generative organs, observation of, male, 90, 140; female, 90, 140, 199. *See also* Masturbation.
- Genius, 289, 335.
- Germ theory, 183. *See also* Bacteria.
- Germicides, 184. *See also* Disinfectants.
- Germs, *see* Bacteria.
- Glass swallowed, 150.
- Globus hystericus, 306, 337, 342.
- Golden rule, 35, 369.
- Gossip, abstinence from, 5, 24, 25, 46, 56, 57.
- Graduated baths, 101.
- Grand mal, 337-338. *See also* Epilepsy.
- Grandiose ideas, 298, 304, 321-322.
- Gymnastics, 22, 212, 218-219, 220.
- Gynecological examinations, preparation for, 198-201; assistance during and after, 200-203; positions, 201-202.
- Habits**, breaking up, 9-11, 85; of nurses and attendants, 19; power of, 225, 252-255, 280.
- Hair, care of, 9, 10, 32, 82, 91. *See also* Shampoo.
- Half bath, 95.
- Hallucinations, 233, 284, 287, 290, 292, 294-295, 310, 312, 314, 316, 319, 326, 336, 384 *et al.* *See also* Illusions.
- Hammock bath, 104-105.
- Handwriting, 320, 329, 334.
- Head, blows and falls, 148; wounds, 158.
- Heart, stimulants, 163; lesions, 96, 119, 180; palpitation, 180-181; symptoms, 134.
- Heat exhaustion, 148. *See also* Sun-stroke.
- Heat, sterilization by, 184.
- Hematemesis, *see* Hemorrhage (Stomach).
- Hematoma, 152.
- Hemiplegia, 147.
- Hemoptysis, *see* Hemorrhage (Lungs).
- Hemorrhage, 157-162, 195; nose, 161-162; mouth, 161; stomach, 161; lungs, 161; rectum, 196, uterus, 196; abdomen, 196; vagina, 204-205.
- Hemorrhoids, 109, 161.
- Hernia, 164.
- Hiccough, 179.
- Hip bath, 109.
- Hippocratic face, 397.
- Home nursing of insane, 380-384.
- Honor, sense of, 23, 28, 45.



- Hospital departments, 21, 29, 37, 43, 57, 65, 68-69, 70, 81; serving food in, 113, 116-117; ventilation, 62, 65-66, 74-75.
- Hot baths, 102-103.
- Hot fomentation compress, 107-108.
- Housekeeping, 19, 54, 68-75, 113-114.
- Hugo, Victor, *Les Misérables*, 239.
- Hydriatrics, *see* Baths.
- Hydrotherapy, *see* Baths.
- Hygiene, physical, 8-9, 259, 275, 353; mental, 259, 268, 273-281; of the ward, 19, 20-21, 54, 60-72.
- Hyperesthesia, 303, 304, 342, 365. *See also* Sensibility.
- Hypersensitiveness, 315, 374, 378. *See also* Hyperesthesia.
- Hypnotism, 224, 344, 352, 377.
- Hypodermic injections, 148, 185, 186.
- Hypomania, 329, 331. *See also* Manic-depressive insanity.
- Hysteria, 98, 133, 146, 297, 299, 302, 303, 304, 307, 341-344, 374. *See also* Anesthesia.
- Hysterical insanity, *see* Hysteria.
- Ice coils, 171.
- Ideas, 274, 283, 284, 285, 286, 289, 293; flight of, 297; imperative, 286, 297, 305, 306; compulsive, 378; grandiose, 298, 304, 321-322.
- Idiocy, 283, 302, 347, 348, 379. *See also* Imbecility.
- Illusions, 233, 284, 292, 294-295, 312, 313, 314, 326 *et al.* *See also* Sense deceptions.
- Imagination, 241.
- Imbecility, 302, 347-348, 379. *See also* Idiocy.
- Imitation, instinct of, 270.
- Imperative ideas, *see* Ideas.
- Improvised splints, *see* Splints.
- Improvised stretcher, *see* Stretcher.
- Impulses, native, *see* Instincts; morbid, 347.
- Impulsive acts, 143, 302, 306, 318, 340, 347, 355.
- Impulsive ideas, *see* Ideas.
- Impulsive insanity, 346-347. *See also* Compulsive insanity.
- Inattentive patients, teaching of, 354.
- Incoherence, 297.
- Incontinence of urine, 138. *See also* Urine.
- Incorrigible patients, 352.
- Individualizing patients, 8, 11, 12, 14, 22, 31, 47, 48, 80, 85, 117, 212, 226.
- Infection psychoses, *see* Toxic psychoses.
- Infectious diseases, 100, 168-178, 184, 399. *See also* Contagious diseases.
- Infirmaries, *see* Hospital departments.
- Inflammatory rheumatism, *see* Rheumatic fever.
- Influenza, 102.
- Insane, number in New York State institutions, 1.
- Insanity, 46, 286, 288, 289-291, 293 *et al.*
- Insanity law, 390-392.
- Insight, 34, 287, 290.
- Insomnia, 98, 102, 180, 224-226, 231-232, 277, 285, 308, 312, 315, 331, 359, 366, 368. *See also* Sleeplessness.
- Instincts, native, 268-271, 273, 279, 353.
- Intellectual field, observations of, 132.
- Intelligence, 246, 283. *See also* Knowledge.
- Intelligent acts, 237.
- Intestinal irrigation, 111.
- Intestinal obstruction, 179.
- Intoxication psychoses, *see* Toxic psychoses.
- Introspection, 237, 246, 270, 280, 288.
- Intubation, 160, 174.
- Inventory of ward furnishings, 54.
- Involution psychoses, *see* Melancholia; Senile insanity.
- Ipecac, 162. *See also* Poisoning.
- Irrigation, 109-112.
- Irritant poisons, 163.
- Isolation, 168, 172, 173, 356, 363, 366, 375, 380. *See also* Seclusion.
- Ivy poisoning, 152.
- Jacksonian epilepsy**, 337, 338.
- James, William, quoted, 236, 253, 255, 276.
- Jealousy, insane, 313-314, 317.
- Jean Valjean, 239.
- "Jekyll, Dr.," referred to, 299.
- Judgment, 224, 241, 246, 266, 269, 283, 284, 286, 289, 292, 293, 298, 301, 337.
- Keys**, care of, 27, 33.
- Kidneys, baths to stimulate, *see* Uremia. *See also* Intestinal irrigation.
- King, Professor, quoted, 280.
- Knowledge, 241, 246; objective, 237; subjective, 237.
- Krafft-Ebing, referred to, 222.
- Labor**, *see* Pregnancy.
- Laboratory, specimens sent to, 43, 123, 138-140.
- Lactational insanity, *see* Puerperal insanity.
- La Grippe, 172.
- Laparotomy cases, 195. *See also* Abdomen.
- Lavage, 109-110, 179, 186. *See also* Stomach tube.
- Les Misérables*, 239.
- Letters, about patients, 25; of patients, 44-46, 57.

- Liberty, deprivation of, 7, 13, 31, 350, 381.
- Licensed sanatoria, number, 1.
- Lifting patients, 76-77.
- Ligation of arteries, 158, 159.
- Local anesthetics, 191. *See also* Anesthetics.
- Local applications, 127, 129.
- Local treatment, 198.
- Lotions, 127.
- Love, instinct of, 269.
- Lumbar puncture, 196-197.
- Lunacy Commission, *see* State Commission in Lunacy.
- Lunacy examiners, 390, 391.
- Lung gymnastics, 218-219.
- Male employees, on women's wards, 26.**
- Malicious patients, 267, 351.
- Malingering, 130.
- Management of pregnancy, 205-206.
- Management of ward, 23, 29, 49-59; system in work, 49, 55; assignment of duties, 49, 68; discipline, 50, 55-56; carrying out orders, 54; attention to details, 54-55; inventory, 54; surveillance, 55; transfer of patients, 56; parole patients, 57; supplies, 57. *See also* Housekeeping.
- Mania, acute, 328. *See also* Manic-depressive insanity.
- Maniacal conditions, 285, 297, 302, 306, 328-331.
- Manic-depressive insanity, 324, 328-335, 363-369. *See also* Depressed patients; Excited patients.
- Mannerisms, 305, 319.
- Massage, 129, 167, 191, 225, 368.
- Masturbation, 85, 90, 140, 210, 302, 317, 365, 378.
- Maudsley, referred to, 352.
- Measles, 173.
- Mechanical feeding, *see* Nasal feeding.
- Mechanical restraint, application of, 28, 46, 47, 191, 358, 369-371; permission for, 28.
- Medicated baths, *see* Baths.
- Medicines, care and administration, 26-27, 127-129, 232, 321, 362.
- Melancholia, 96, 323-325, 360-362. *See also* Depressed patients.
- Memory, 239, 282, 292, 293, 294, 296, 297, 315, 318, 321, 325.
- Meningitis, cerebro-spinal, 172.
- Menstrual disorders, 103, 109, 112, 140, 307.
- Mental states and bodily reactions, 236, 238, 245-246, 249, 260, 262, 273-274, 276, 292, 304, 306.
- Meyer, Dr. Adolf, quoted, 273.
- Mind, 236, 237, 238, 240, 246, 292.
- Minor operations, 193, 196. *See also* Surgical technique.
- Miscarriage, threatened, 204-205.
- Moods, 264, 284.
- Moral needs of patients, 7, 11, 14, 31, 35, 48.
- Morphinism, 225, 314-316, 359, 360. *See also* Drug habitué.
- Motor expressions of insanity, 304.
- Moving injured person, 165, 166.
- Multiple personality, 229, 343. *See also* Hysteria.
- Mumps, 172.
- Munchausen, referred to, 321.
- Muscular incoördination, 305.
- Mushroom book, 218.
- Music on wards, 51, 52, 216, 220.
- Mutism, 303.
- Mysophobia, 346.
- Nails, care of, 30, 90.**
- Narcotic poisons, 163.
- Nares, plugging, 162.
- Nasal douche, 162.
- Nasal feeding, 123-126, 149.
- Native instincts, *see* Instincts.
- Native reactions, 269-271.
- Nature study, 216-218.
- Needles in body, 152.
- Negativism, 305. *See also* Will.
- Neptune girdle, 107.
- Nerves, motor, 240; sensory, 240, 242, 253.
- Nervous prostration, *see* Neurasthenia.
- Nervous system, 238-239, 240-241, 242-243, 246, 253, 259, 266, 283.
- Neurasthenia, 97, 98, 108, 129, 225, 277; acquired, 344, 374; congenital, 345.
- Neurotic children, training, 277.
- New York State Hospitals, 1-2.
- Night nurses, 3, 30, 57, 71, 86, 139, 228-235.
- Night reports, 230.
- Night sweats, 94, 177, 178. *See also* Tuberculosis.
- Nightingale, Florence, quoted, 49.
- Nightmare, 224.
- Nipples, 204, 207.
- Noise, avoidance of, 21-22, 208, 230-231, 232, 246, 356.
- Normal salt solution, 148, 171, 184-185, 190, 196.
- Nosebleed, 161-162.
- Nurses, duties, 5, 24; arduousness of work, 6, 15-16; wages, 2, 3, 4; qualifications, 6, 7, 23, 24; necessity for growth, 7, 14, 15; influence of, 14; rules for, 17-33; appearance and dress, 18-21; unbecoming habits, 19; behavior, 19, 23, 25, 26, 33, 52, 56; duties to one another, 24; to officers, 24; to friends of patients, 24, 25;

- sense of honor, 28, 228, 234; self-control, 46, 47, 275; discretion, 195, 203, 399, 400. *See also* Attendants; Uniforms; Night nurses; Training school.
- Nutrient enemata, 121-122.
- Objective symptoms**, 131-132. *See also* Symptoms.
- Observation of symptoms and conditions, *see* Symptoms.
- Obsessions, 306, 346. *See also* Ideas.
- Obstetrical nursing, 174. *See also* Pregnancy.
- Obstruction, intestinal, 179.
- Occupation of patients, 19-20, 29-30, 33, 44, 58, 70, 75, 81, 209-213, 354, 357.
- Open-door system, 350.
- Operations, minor, 193, 196. *See also* Surgical technique.
- Optimism, 8, 258, 273-274, 322.
- Outdoor amusements and interests, 20, 58, 216-218, 334.
- Overwork, 375-376.
- Ownership, instinct of, 271. *See also* Collecting propensity.
- Pack**, cold, 98-100.
- Pain habit, 253.
- Pallor, significance, 140.
- Palpitation of heart, 180-181. *See also* Heart.
- Paranoia, 289, 335-337, 371-372.
- Paroles, 56-57.
- Patients, number in New York State Hospitals, 1; consideration for, 11-14, 29, 31, 38, 39-43, 47, 48, 69, 70, 115, 187, 201, 395; fastidious care of, 8, 30, 90; reception of, 31, 34-44; general care of, 10, 32; general appearance, 131; behavior, 132; general training of, 212. *See also* Occupation of patients.
- Perception, 241, 243-244, 282, 294.
- Perineal operations, after care, 204.
- Personality, dual, 299; multiple, 299.
- Persuasion, 36, 128, 257, 260, 352, 379, 395.
- Perversions, 300, 302.
- Pessimism, 259, 273-274, 277.
- Peterson, Dr. Frederick, referred to, 371.
- Petit mal, 337, 338. *See also* Epilepsy.
- Phobias, 345-346, 378. *See also* Fear.
- Phthisis, 94, 98, 133, 140, 176, 307. *See also* Tuberculosis.
- Pillows, arrangement, 77, 78.
- Placenta, 184, 206.
- Plasticity, 252-253.
- Pleurisy, 179.
- Pneumonia, 140, 175-176, 180, 183, 184.
- Poison ivy, 152.
- Poisoning, 162-163.
- Poisonous gases, 148-149.
- Poisons, care of, 127.
- Powder burns, 154.
- Precocious children, 277.
- Precocious dementia, *see* Dementia præcox.
- Pregnancy, 184, 204, 205-206.
- Preparation for operations, *see* Surgical technique.
- Pride, instinct of, 271.
- Private households, insane in, 380-388.
- Probationers, 2, 24, 27, 52-53, 57, 349.
- Protection sheet, *see* Mechanical restraint.
- Psychasthenia, 97, 346, 375-376, 378-379.
- Psychiatry, 282, 308 *et al.*
- Psychic epilepsy, 339.
- Psychic treatment, *see* Psychotherapy.
- Psychology, 236-251, 254, 263-272, 282-284, 368, 369 *et al.*
- Psychopathic states, 344-347. *See also* Psychasthenia.
- Psychotherapy, 256-262, 264 *et al.*
- Puerperal insanity, 207-208, 386.
- Pugnacity, instinct of, 270.
- Pulse, observations, 37, 38, 134-135, 206, 245, 307 *et al.*
- Punctured wounds, *see* Wounds.
- Quarantine**, 173, 174.
- Reaction time**, 243.
- Reading, value of, 210, 215-216.
- Reasoning, 241, 246, 269, 292, 336 *et al.*
- Reception of patients, 31, 34-43.
- Rectal feeding, 121-122, 160. *See also* Enemata.
- Reduction, mental, 299, 303. *See also* Dementia.
- Reflex acts, 238.
- Reflexes, disturbances in, 304, 310.
- Relaxation, 228, 281.
- Report of symptoms and conditions, *see* Symptoms.
- Resistive patients, 36, 46, 47, 91, 120, 121, 122, 124, 126, 127, 150, 201, 394, 395, 360.
- Respiration, artificial, 148, 149, 206; observations, 37, 38, 133, 307.
- Responsibility, 261.
- "Rest cure," 374-375.
- Restlessness, 22, 191, 225, 308, 325-327, 355, 387, 388. *See also* Senile insanity.
- Restraint, *see* Mechanical restraint.
- Resuscitation, from anesthesia, 188; of new born, 205-206.
- Retardation, 243, 285, 297, 333, 368. *See also* Reaction time.
- Retention of urine, 122, 138. *See also* Urine.
- Rheumatic fever, 103, 175, 180.

- Rigor mortis, 399.  
 Roman Catholics, 397.  
 Rules for nurses and attendants, 17-33.  
 Rumination, mental, 346.
- Safety sheet**, *see* Mechanical restraint.  
 Salem witchcraft, 291.  
 Saline enemata, *see* Normal salt solution.  
*See also* Enemata.  
 Sane delusions, 291.  
 Sane hallucinations, 295.  
 Sanitaria, licensed, unlicensed, 1; nursing in, 388-389.  
 Scalds, 152-154.  
 Scalp wounds, 151-152. *See also* Wounds; Hemorrhage.  
 Scarlet fever, 169, 180, 184.  
 Scotch douche, 108.  
 Scybala, 137. *See also* Feces.  
 Seat of intelligence, 283. *See also* Brain.  
 Seclusion, 28, 31, 46, 47, 356, 369. *See also* Isolation.  
 Secretions, altered, 306-307, 331.  
 Self, 248-251, 258, 342. *See also* Ego.  
 Self-abuse, *see* Masturbation.  
 Self-mutilation, 303, 353, 386.  
 Senile insanity, 91, 98, 142, 225, 232, 270, 304, 308, 325-327, 362-363, 387-388.  
 Senility, physiological, 325.  
 Sensation, 239, 241, 242, 243-244, 246, 247, 282, 283, 286.  
 Sense deceptions, *see* Hallucinations; Illusions.  
 Sensibility, 243, 246, 275, 300, 344, 358, 366. *See also* Anesthesia; Hyperesthesia.  
 Sensorium, 224.  
 Sensuality, 210. *See also* Masturbation.  
 Serving of food, 11, 21, 32, 113-119.  
 Sexual equivalents, 302.  
 Shampoo, 40-41, 177. *See also* Hair; Beards of patients.  
 Shaving for operations, 192. *See also* Surgical technique.  
 Sheet bath, 96-97.  
 Shock, 148, 153, 157, 184, 192, 195.  
 Shortcomings, attitude toward, 263-266, 280-281.  
 Signs, of approaching death, 397; of death, 398-399.  
 Silent symptoms, 131.  
 Sitz bath, 109.  
 Skin, grafting, 196; observations of, 140.  
 Skull fractured, *see* Fractures.  
 Sleep, importance of, 30, 223, 235, 334; disorders, 308; conditions favoring, 226-227, 231, 232.  
 Sleeplessness, *see* Insomnia.  
 Smallpox, 184. *See also* Vaccination.  
 Somatic sense deceptions, 296, 298. *See also* Sense deceptions.  
 Somnambulism, 224.
- Sordes, 358.  
 Special attendant, wages, 4.  
 Speech disorders, 303, 305, 311, 320, 339.  
 Sphygmograph, 245.  
 Splints, 165.  
 Sponging, 93, 94.  
 Sprains, 38, 112, 166-167.  
 Sputum, care of, 66, 85, 168, 175, 176-177, 184; observation of, 134; specimens, 138-139. *See also* Tuberculosis.  
 Stains, removal, 74, 75.  
 State Commission in Lunacy, 1, 4, 18, 390.  
 State Hospitals, number in New York, 1; addresses, 1-2; management, 1; general plan, 4; service in, 2-5. *See also* Attendants; Nurses; Training schools.  
 Status epilepticus, 339, 374.  
 Steam, bath, 104; sterilization by, 184.  
 Stereotyped movements and attitudes, 305, 319.  
 Sterilization, 184.  
 Stigmata, physical, 317, 339, 347.  
 Stings, 152.  
 Stomach, contents, 122-123. *See also* Test breakfast; Lavage.  
 Stomach tube, 122-123, 162.  
 Stools, *see* Feces; Bowels.  
 Strangulated hernia, 164.  
 Strangulation, 149.  
 Stretcher, 165.  
 Stuporous cases, 43, 129, 170, 357-358. *See also* Delirious patients.  
 Styptics, 159.  
 Subconscious life, 242, 343-344.  
 Subjective symptoms, 130-131, 132.  
 Suggestion, 352, 376-377. *See also* Hypnotism; Persuasion.  
 Suicidal patients, 27, 31-32, 91, 114, 115, 135, 143, 160, 176-177, 196, 200, 208, 234, 306, 324, 342, 361-362, 368-369, 375, 382, 383, 386, 396.  
 Sulphate, of zinc, 162; of copper, 162.  
 Sunstroke, 147.  
 Supervisors, 23, 27, 42, 45, 49, 71 *et al.*  
 Surgical technique, 184, 185-186, 191-194, 202-203.  
 Suspicions, insane, 128, 207, 313-314, 316, 336, 337, 372. *See also* Delusions.  
 Sympathy, 6, 12, 14, 24, 35-36, 47, 48, 234, 257, 260-261, 266, 269, 271-272, 277, 352.  
 Symptoms, observation and report of, 8, 27, 32, 33, 36-39, 43, 53-55, 87, 128, 134, 143, 177, 199, 206-207, 229-230, 231, 233, 234, 307, 397; subjective, 130-131, 132; objective, 131-132.  
 Syncope, 144, 157.
- Table manners, of patients, 11.  
 Tapping chest, *see* Heart.



- Tartar emetic, 162.  
 Taxis, 164.  
 Teeth, care, 10, 30, 83, 115; removal before anesthesia, 187.  
 Telephone, 57.  
 Temperature, baths, 92; patients, 37, 135, 147, 177, 307, 357; wards, 66-67.  
 Test breakfast, 122-123.  
 Test phrases, 303, 320.  
 Therapeutics, 256. *See also* Psychotherapy.  
 Thermometer, bath, 92; use of, 135, 150; ward, 66.  
 Thirst after operations, 190, 194.  
 Thorndike, Edward L., quoted, 279.  
 Throat, specimens from, 140; compress, 105-106, 189. *See also* Diphtheria.  
 Toilet of patients, 30, 81-83, 90.  
 Tonsillitis, 105, 178, 180.  
 Tourniquet, 158, 195.  
 Toxic psychoses, 191, 207, 225, 233, 296, 302, 310-317, 358-359. *See also* Exhaustion psychoses.  
 Toxins, 184.  
 Tracheotomy, 160, 174.  
 Training School for Nurses, 1, 2-3, 57, 202; examinations, 3; length of course, 3; nature of course, 3; graduation, 3; lectures, 120; discipline, 382.  
 Transfers, patients, 56; nurses and attendants, 4.  
 Transfusion, 171.  
 Transportation of patient, *see* Conveyance of patients.  
 Trees, books concerning, 218.  
 Tremors, 304, 311, 320.  
 Trephining, 165-166.  
 Trophic disorders, 86, 306, 320. *See also* Bed sores.  
 Tubercular wards, 113.  
 Tuberculosis, 66, 139, 176-178, 218-219.  
 Turpentine stupes, 171, 179, 190.  
 Twenty-four hours' specimen, 139. *See also* Urine.  
 Typhoid fever, 100, 170, 171, 184.  
 Ulysses and the sirens, 260, 280.  
 Unclean patients, 21, 70, 79, 80, 81, 84, 85, 87, 121, 177, 228-229, 234, 353, 355, 356, 370.  
 Unconsciousness, 96, 118, 129, 144-148, 149, 189, 247. *See also* Coma; Sleep.  
 Uniforms, 2, 17, 18, 56.  
 Unreality, sense of, 300, 324.  
 Untidy patients, *see* Unclean patients.  
 Uremia, 102, 138, 181, 184, 225; convulsions in, 145-146; treatment, 146.  
 Urine, specimen after admission, 43, 139; observation of, 137-138, 186, 204; suppression, 138. *See also* Bladder.  
 Uterine disorders, 109; hemorrhage, 109; prolapsus, 109; leucorrhea, 140. *See also* Menstrual disorders.  
 Vacation, 3.  
 Vaccination, 172-173; virus, 173.  
 Vaginal douches, 112, 122, 199.  
 Vaginal irrigation, *see* Vaginal douches.  
 Vaginal operations, 192.  
 Valjean, Jean, 239.  
 Valuables of patients, 394, 400. *See also* Belongings.  
 Valvular heart lesions, 180.  
 Vapor baths, 103-104.  
 Varicose veins, 159.  
 Vaso-motor manifestations, 306.  
 Vegetative functions, 238, 307.  
 Ventilation, 21, 54, 60-67, 113, 231, 232-233.  
 Verbigeration, 303.  
 Vermin, 38, 41, 70, 73.  
 Violent patients, 22-23, 27, 33, 41, 46, 121, 125, 164, 200, 201, 355-356 *et al.*  
 Virus, 173.  
 Visitors on wards, 24-25, 26, 32, 52, 57, 70.  
 Vital functions, changes in, 307.  
 "Voices," 287, 319. *See also* Hallucinations.  
 Volition, *see* Will.  
 Voluntary acts, 238.  
 Vomitus, 136, 149, 162, 189.  
 Wages, 2, 3-4.  
 Ward, adornment, 19-20, 113, 212, 213; hygiene of, 19, 21, 60-72. *See also* Management of ward; Noise, avoidance.  
 Warm full bath, 102.  
 Washing stomach, 109-110.  
 Weight, observations, 36-37, 55, 115-116, 117, 308, 324, 363.  
 Wet pack, 98-100.  
 Will, 259-260, 286, 292, 293, 301, 302-303, 305, 378.  
 Winternitz Combination Compress, 107.  
 Witchcraft, 291.  
 Worry, 274, 334 *et al.*  
 Wounds, 151-152, 159, 160.  
 Zinc sulphate, 162. *See also* Emetics.





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